CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health & BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/18/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS:

C P Force 3/19/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 16501 9 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1212

G 1650T Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 747 Vine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 747 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William Norris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1903

8. AGE: Years 41 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant William Norris

(b) Address 747 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1600 Brayton Ave Hunting & Williams, Inc.

APR 24 1944 (Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944 at 8 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to 4/17 1944, and that I last saw h— alive on 4-17 1944.

Immediate cause of death Pulmonary Phthisis — Duration 1 hr 7 D

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature R. H. Hatcher

Address 1725 Pa Ave Date signed 4/23/44

G 16502

16502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 N. Spring St-D
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Honesty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1883

8. AGE: Years	Months	Days	If less than one day
61	3	4	hr. min:

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Alias Green
13. Birthplace D.C.

MOTHER
14. Maiden Name Phebe Barber
15. Birthplace D.C.

16 (a) Informant: Edna Platter PLANTER
(b) Address 26 N. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bragg [illegible]

19 APR 24 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21/44 at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 4/24/44

G 16503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 16503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 W. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 34 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Adams Hamilton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Silas Marland Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 1860

8. AGE: Years 83 | Months 5 | Days 28 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Orson Adams
13. Birthplace Maryland

MOTHER
14. Maiden Name Anne L. Fisher
15. Birthplace Baltimore, Md.

16 (a) Informant Horace S. Whitman
(b) Address 34 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Henry W. Jenkins Sons Inc.
(b) Address McCulloh & Eutaw Sts.

19 44 APR 24 1944 (Date rec'd by Reg.) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 24th 1944, at 3 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1944, to April 24th 1944, and that I last saw her alive on April 22nd 1944.

Immediate cause of death Hypostatic pneumonia
Due to Arter-Sclerosis

Due to

Other Conditions Arter sclerosis Cerebral,
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration
yrs.
mos.
days
hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. T. Coldstead M. D.
Address 334 N. Calvert St Date signed Apr 24 1944

G 16503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 16504

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4631 Kiswick Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltotety
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4631 Kiswick Rd (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Austen Stokes

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Stokes
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-19-1859

8. AGE: Years 83 | Months 9 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Dr Philip Austen
13. Birthplace Md.

MOTHER
14. Maiden Name Carolina V. Dushane
15. Birthplace Md.

16 (a) Informant Mr. Geo. C. G. Stokes (son)
(b) Address 4631 Kiswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W. Lexington St.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

APR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 23 — 1944 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943, to Apr 23 1944 and that I last saw her alive on Apr 22 1944

Immediate cause of death Myocardial insufficiency — Chr. Myocarditis — Duration 1 day 2yrs

Due to ... Duration ...

Due to ... Duration ...

Other Conditions Arteriosclerosis — Duration 5yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Keller, M. D.
Address 222 W. Monument Date signed 4/24/44

16505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 16505 Registered No. 95c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md Gen
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford Co.
(c) City or town ~~Balto~~ Bel-Air, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Maitland Ave (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country — — —

3 (a) FULL NAME William D. Dunning (WILLIAM DOWNS DISNEY)

MEDICAL CERTIFICATION

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 220-20-7734

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lola S Dunning
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.) October-11-1896

8. AGE: Years 47 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Supt-Reproducer Plant
11. Industry or business Lot & S Govt-(Edgewood)

FATHER: 12. Name William Dunning
13. Birthplace Md
MOTHER: 14. Maiden Name Nellie Anderson
15. Birthplace Md

16 (a) Informant Mrs Lola S. Dunney-(wife)
(b) Address Bel-Air-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-26-44 (month) (day) (year)
(c) Cemetery or crematory Trinity M.E. Cem.
Location Edgerton-Md.-R.F.D.

18 (a) Funeral director Stewart Mason Co.
(b) Address 1082 W Monument Ave.

19 (a) (Date rec'd by Registrar) APR 21 1944 (b) Registrar Huntington Williams, M.D.

VS 150

20. DATE OF DEATH 4-22- 1944 at 8 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 19 44 to 4-22 1944.
and that I last saw h alive on 4-22 1944.

Immediate cause of death Acute coronary insufficiency — Duration

Due to Cardiac decompensation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William D. Mitchell M. D.
Address Md. Gen. Hosp Date signed 4-22-44

G 16506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16506

Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33 St
(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hooper S. Miles, Jr. (Hooper Steele Miles, Jr.)

3 (b) If veteran, name war none | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 8 1927

8. AGE: Years 16 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Salisbury-Md (Town, county, and state)

10. Usual Occupation School-boy

11. Industry or business

FATHER
12. Name Hooper S. Miles
13. Birthplace Cambridge-Md

MOTHER
14. Maiden Name Frances Williams
15. Birthplace Salisbury-Md

16 (a) Informant Hooper S Miles (father)
(b) Address 4101 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. Mowen Sec.) 106 W. North Avenue

19 (a) APR 24 1944 (Date received by Registrar) By Hunter Miles, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23- 1944 at 3:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractures cervical vertebrae

Due to

Other Conditions Contusions, abrasions of head, brain.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-23- at A M.
(b) Where did injury occur? Balto. Co. Dayton ave., near Falls Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck telegraph pole

23. Signature Howard J. Mackenzie M.D.
Medical Examiner.
Date signed 4-23-44

G 16507 AB-87459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G 16507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 hrs. 29 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 1022 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl-Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15-1944

8. AGE: Years | Months | Days 1 | If less than one day 35 hr. 29 min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Clifton Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Freda Davis
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremated (b) Date thereof 4-21-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B. C. H. Crematory.
Location 4940 Eastern Ave

18 (a) Funeral director B. C. H. Crematory
(b) Address 4940 Eastern Ave

19 Date received APR 24 1944 (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1944, at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944 to 4-16 1944 and that I last saw her alive on 4-16 1944

Immediate cause of death: Congenital Atelectasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Russell M.D.
Address Balto. City Hosp. Date signed 4/26/44

16508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16508
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Elizabeth Denby

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1869

8. AGE: Years 75 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Denby
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Shaw
15. Birthplace Ohio

16 (a) Informant Miss. Mary W. Toner
(b) Address 2307 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) Date received APR 24 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1944 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1944 to 4-23 1944, and that I last saw her alive on 4-23 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Bilateral Bronchopneumonia

Due to Arter

Other Conditions Arteriosclerotic Heart Disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen J. VanLill, M.D.
Address Union Memorial Hosp. Date signed 4-25-44

16509 TN. 87537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V1 12B G 16509 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 N. Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Buechner (John Adam Buechner)
3 (b) If veteran, name war None
3 (c) Social Security Account No. 216-01-2752
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 22 1879
8. AGE: Years 65 Months 2 Days 0 If less than one day hr. min.
9. Birthplace Maryland (Baltimore) (Town, county, and state)
10. Usual Occupation Clothing cutter
11. Industry or business Clothing Mfg.

FATHER
12. Name John A. Buechner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. [illegible] Binan
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd. Balto: Md.
18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Ave. Balto: Md.
19 (Date received by registrar) APR 24 1944 Huntingtown, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1944, at 8:20 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1944 to 4/22 1944, and that I last saw h[illegible] alive on 4/22 1944.

Immediate cause of death: Pulmonary TBC — Duration: 2
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Seigman M.D.
Address 15 CH Date signed 4/25

VS 150

Please write the causes of death clearly and legibly. Punctuate; please write as specially important. Physicians: please write

G 16510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 16510

70486656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Several yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Albert Stanley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. ?, 1888

8. AGE: Years	Months	Days	If less than one day
56	3 2 ?	?	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Albert Stanley (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Caroline ? (d)
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.
18 (a) Funeral director Joseph B. Lokie
Address 1304 N. Central Ave. Huntingdon Williams, M.D.
19 (Date received by registrar) APR 24 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944 19 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1944 to 4/26 1944 and that I last saw h. alive on 4/26 1944.

Immediate cause of death	Duration
Cerebral Accident	two
Due to Hypertensive cardiovascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattina M.D.
Address B. C. H. Date signed 4/24/44

G 16511 ✓ G 16512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 327 Brooklyn Road
(c) Hospital or institution:

27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Brooklyn Road (If rural give location)
(e) Citizen of foreign country? Brooklyn (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Brown Fischer Speer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife J. L. Dawson Speer Jr. 6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 6 1899

8. AGE: Years	Months	Days	If less than one day
44	9	17	hr. min.

9. Birthplace Stoneleigh Balto Co (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leopold C Fischer
13. Birthplace Balto Md

MOTHER
14. Maiden Name Grace Brown
15. Birthplace Stoneleigh Balto Co Md

16 (a) Informant J. L. Dawson Speer Jr.
(b) Address 327 Brooklyn Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 26 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Orchard

19 (a) (Signature and title) (b) H. Wright Williams M.D.

APR 24 1944

MEDICAL CERTIFICATION

45

20. DATE OF DEATH April 23 1944, at 11 A.M.

21. I certify that I took charge of the remains described above, held an On section thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed April 23 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16512 ✓ Registered No. G 16512 108

G 16512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 E. Madison
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Supp 2
(e) Length of stay in Baltimore (yrs., mos., or days) Supp

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No 1910 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian R. Wilmore

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race b. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 20 1914

8. AGE: Years 29 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Harry Wilmore
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Bowman
15. Birthplace Fair-fax Co. Va

16 (a) Informant Carrie Wilmore
(b) Address 1910 E. Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto Md.

18 (a) Funeral director Mrs Ida Bayly
(b) Address 1421 Jefferson St

19 (a) (b)

APR 21 1944 Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to April 22 44.
and that I last saw h alive on 19

Immediate cause of death Acute Pleuro Pneumonia — Duration April 22

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? (Specify type of place)
(e) Means of injury No

23. Signature Leo S. Allen M. D.
Address 121 August Ave Date signed 4-22-44

Please write the causes of death clearly and legibly. Physicians: please write so that the information is especially important. Be sure that the information is correct age is especially important.

G 16513 ✓ G 16513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 E Gittings St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zachariah James NICHOLS

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-14-1799

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maggie S. Nichols
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-27-1871

8. AGE: Years 72 yrs | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name John Nichols
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Frances Hubbard
15. Birthplace Baltimore Md.

16 (a) Informant Maggie S. Nichols
(b) Address 106 E. Gittings St.

17 (a) Burial (b) Date thereof 4/26/1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Flynn & Flaherty
(b) Address 1416 Light St.

19 (a) Date received APR 27 1944 (b)
(Registrar)

Hunting for William Burgh

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 1.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944 to 4/24 1944, and that I last saw h[illegible] alive on 4/24 1944.

Immediate cause of death: Cerebral hemorrhage — Duration 18 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest L. Ward M. D.
Address South Balt. Gen'l Hosp. Date signed 4-24-44

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statements of the cause of death as directed are necessary for the correct application of the International Rules. Causes of death which may be the result of occupation or which occur in connection with any trade, employment or place of work, and the primary cause of which is not apparent, should be reported fully, as these are especially important.

VS 150

G 16514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G 16514 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St
(c) Hospital or institution:
St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1871 Covington St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Groves (Groves)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Edward A. Groves | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7 - 1894

8. AGE: Years 49 | Months 6 | Days 17/16 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name John Hoyle
13. Birthplace Baltimore Md.
14. Maiden Name Mary Foley
15. Birthplace Baltimore Md.

16 (a) Informant Edw. A. Groves Jr.
(b) Address 1871 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) (Date rec'd by reg.) APR 24 1944 Registrar Williams, M.D.

PLEASE WRITE PLAINLY. Fill in all blanks. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1944, at 10 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1944 to 4-23 1944 and that I last saw h[illegible] alive on 4-23 1944.

Immediate cause of death	Duration
Acidosis	
Due to Uremia	
Due to Peritonitis (?)	
Other Conditions Chronic cholecystitis Cholelithiasis	

(Include pregnancy within 3 months of death)
Date of operation 4-15-44
Major findings of operation: Cholelithiasis Cholecystotomy performed
Date of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kelvin L. Jamonski
Address [illegible] Date signed 4/25/44 M.D.

16515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16515

Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 E. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Burch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Edward C. Burch
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 21 1885

8. AGE: Years 59 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Muhlmichel
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Engale
15. Birthplace Baltimore Md.

16 (a) Informant Edward C. Burch
(b) Address 2519 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd - Balto Md.

18 (a) Funeral director John E. Melly Inc
(b) Address 2435 E. Oliver St

19 APR 24 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VE 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21-1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/44 19 to 4/21/44 19, and that I last saw h[illegible] alive on 4/[illegible] 19 44

Immediate cause of death: Hypertensive Cardio-Vascular disease. — Duration 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Baum
Address 1501 N. Wilton Ave Date signed 4/22/44

G 16516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16516 Registered No. 632

PLEASE WRITE PLAINLY with pencil or pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 5, (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Valanovski
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Wenceslaus Valanovski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1876

8. AGE: Years	Months	Days	If less than one day
67	4	11	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Valis
13. Birthplace Bohemia

MOTHER 14. Maiden Name Anna Dedouch
15. Birthplace Bohemia

16 (a) Informant James Valanovsky
(b) Address 501 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director J. J. Enoch & Son
(b) Address 700 N Eutaw St

APR 21 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1944, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1944, to 4-22 1944, and that I last saw her alive on 4-22 1944

Immediate cause of death	Duration
Thrombosis coronary	
Coronary Failure gradual	
Due to	
Due to	
Other Conditions Appendicitis acute?	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A. Brill M.D.
Address Univ Hospt. Date signed 4-23-44

G 16512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G 16512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5100 Whitford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Whitford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frances E. Bacon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife J. Carroll Bacon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1885

8. AGE: Years 58 | Months 5 | Days 11 | 13 If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Samuel Myers
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Adler
15. Birthplace Maryland

16 (a) Informant Mr. J. Carroll Bacon
(b) Address 5760 Whitford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)
(c) Cemetery or crematory St. James
Location Monkton Maryland

18 (a) Funeral director Harry A. Wilhelm
(b) Address 4016 Edmondson Ave.

APR 24 1944 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

PLEASE PRINT plainly with pen and ink. Be sure to write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9-1943 to April 22 1944 and that I last saw h W. alive on 4-21 1944

Immediate cause of death: Carcinoma Peritoneum of Stomach. — Duration 1 yr.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify public place) While at work?
(e) Means of injury

23. Signature Harry F. Bacon Jr. M. D.

Address 5267 York Rd Date signed 4/23/44

G 16518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 16518 Registered No. 77D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Johns Hopkins Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1820 E. Oratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Crawford Caldwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1897

8. AGE: Years 46 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Crofton Kentucky (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Hercules

FATHER 12. Name Felix Coldiron

13. Birthplace Kentucky

MOTHER 14. Maiden Name Mary Lewis

15. Birthplace Kentucky

16 (a) Informant Willis Coldiron

(b) Address Cumberland Kent.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 26 44 (month) (day) (year)

(c) Cemetery or crematory Location Pattridge Kentucky

18 (a) Funeral director Heinemann Bros

(b) Address 31 S Broadway

19 (a) (b)

APR 24 1944

VR 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at 9:30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to Chronic Alcoholism.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-24-44; 9:45 A M.
(b) Where did injury occur? Baltimore, Md
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? No.
(d) Means of injury Fell to floor

23. Signature H. J. Wollenberg M.D.
Medical Examiner.
Date signed April 24, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 16519

Registered No. 111c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. Gen. Hosp.
(c) Hospital or institution: Howard & Madison 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Woodstock Ave. #13 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Joseph T. Kerr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7-1891

8. AGE: Years	Months	Days	If less than one day
53	0	16	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name John Kerr
13. Birthplace England

MOTHER
14. Maiden Name Mary Dench
15. Birthplace England

16 (a) Informant Carrie Kerr
(b) Address 3411 Woodstock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John G. Connelly
(b) Address 416 Carter Ave. Cmty

(a) (Local registrar) (b) Huntington Williams, M.D.

APR 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 4:06 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944 to April 23 1944, and that I last saw h/m alive on April 23 1944

Immediate cause of death: Hypostatic pneumonia — Duration

Due to

Due to (Undetermined)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed April 23, 1944

G 16520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16520 Registered No. 1702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Emg
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virgil B. Garland

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1944 at 2:45 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6 - 1913

8. AGE: Years	Months	Days	If less than one day
31	2	17	hr. min.

9. Birthplace Tennessee
(Town, county, and state)

10. Usual Occupation Tool Crib # 2

11. Industry or business Glenn Martin Co.

FATHER
12. Name Elisha Garland
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Cora M. Leach
15. Birthplace Tenn.

16. (a) Informant Mrs. Ruby Roark
(b) Address Bird Rock Rd. Middle River

17 (a) Flans. (b) Date thereof 4-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lelewood
Location Tennessee

18 (a) Funeral director Guy G. Connelly
(b) Address 4801 Eastern Ave. Balto

APR 24 1944

19 (a) Hiram Williams M.D.
(Date rec'd by registrar) Registrar

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-23-44 2:45 P. M.
(b) Where did injury occur? Eastern Ave. Martin's # 2 Plant
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
(d) Means of injury Pedestrian struck by auto

23. Signature H. J. Wellenmeyer M.D.
Medical Examiner.
Date signed April 24, 1944.

VS 151

G 16521 X ✓ G 16521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. 2-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Compromise Court, Victory Villa
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward S. Everett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Claire Hensel Everett

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Dec. 19-1904

8. AGE: Years	Months	Days	If less than one day
39	4	4	hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Flight Inspector

11. Industry or business Glenn Martin Co.

FATHER
12. Name Paul Everett
13. Birthplace Canada

MOTHER
14. Maiden Name Unknown
15. Birthplace Canada

16 (a) Informant Mrs Claire Everett
(b) Address Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John B. Connolly
Address 418 Eastern Ave. Essex

19 (a) APR 24 1944 (Date rec'd by registrar) (b) Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Deep laceration & compound fracture of left leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 23 1944 at 2:45 A.M.
(b) Where did injury occur? Eastern Blvd, Essex
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Auto accident

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed April 23 1944

16522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C 16522

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 E. Preston st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 E. Preston st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Rebecca Lambert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Lewis Lambert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1866

8. AGE: Years	Months	Days	If less than one day
78	2	7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Charles R. Conaway
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Thayer
15. Birthplace Md

16 (a) Informant Mrs Lydia Affayson
(b) Address 804 E. Preston st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

APR 25 1944 (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd 1944 at 6 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to April 23 1944, and that I last saw h alive on 4/23 1944.

Immediate cause of death	Duration
General Arteriosclerosis	5 yrs.
Chronic Myocarditis	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron L. Solomon
Address 29 S Broadway Date signed 4/26/44

G 16523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16523

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(or) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 149 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Markland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife Lamar Chas. Markland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1878

8. AGE: Years 65 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace New York N. Y. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Robert Keller
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Kadlent
15. Birthplace Germany

16 (a) Informant Lorraine Markland
(b) Address 149 N. Linwood Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Baltimore St

19 APR 25 1944 (Entered by Registrar) (b) Hunting for Williams, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 1A. M

21. I certify that I took charge of the remains described above, held an ~~Inquest~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed April 24, 1944.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Q 16524 — 16524

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH Beck Diagnostic Clinic

Registered No.

CITY OF BALTIMORE: (No. 100 E. 23rd St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Mrs. Burnman (Ada) H. Bortner

If U. S. Veteran specify WAR

(a) Residence: No. 2413 Brambleton Rd. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Burnman B. Bortner

6. DATE OF BIRTH (month, day, year) May 22nd 1895

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	11	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Teacher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Public School

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Charles Fisher

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Altona Pote

16. BIRTHPLACE (city or town) (State or country) Pa.

17. INFORMANT Burnman B. Bortner
(Address) 2413 Brambleton Rd

18. BURIAL, CREMATION, OR REMOVAL
Place Druid Ridge Date April 26th 1944

19. UNDERTAKER Wm Cook Inc
(Address) 1217 St Paul St.

APR 25 1944, 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 23, 1944

22. I HEREBY CERTIFY, That I attended deceased from April 20, 1944 to April 23, 1944

I last saw he/she alive on April 23, 1944 Death is said to have occurred on the date stated above, at 2 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Malignant Hypertension	1943
Cerebral Hemorrhage	April 20 1944

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Louis J. Kroll M. D.

(Address) 100 E. 23rd St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V S 8

Huntington Williams, M.D.

C 16525

452330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

C 16525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6512 St. Helena Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Shealey

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 213-09-4064

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-03

8. AGE: Years 40 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Bricklayer

11. Industry or business

FATHER: 12. Name Harry Shealey
13. Birthplace Md.

MOTHER: 14. Maiden Name Catherine Kelly
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 27/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) [illegible]
(Date rec'd by registrar) APR 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944 to April 23 1944 and that I last saw h alive on April 23 1944.

Immediate cause of death Respiratory Failure — Duration

Due to Cardiac failure — Duration

Due to Rheumatic heart disease, inactive, & mitral stenosis — Duration 35 yrs

Other Conditions insufficiency & aortic stenosis and insufficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Geneen M. D.
Address J. Hopkins Date signed 4-13

VS 150-

G 16526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 16526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1511 Northwick Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1511 Northwick Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WASHINGTON WRIGHT

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lyde A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1861

8. AGE: Years 83 | Months 2 | Days 1 | If less than one day: hr. min.

9. Birthplace: Norfolk, Va.
(Town, county, and state)

10. Usual Occupation: Retired - Supt.

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: William Wright
13. Birthplace: England

MOTHER
14. Maiden Name: Eliza Strepple
15. Birthplace: Baltimore

16 (a) Informant: Mr. K. T. Wright
(b) Address: 202 W. Penna. Ave., Towson

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)

(c) Cemetery or crematory
Location: Norfolk, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) APR 25 1944 (b) Huntington, W. Va. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1944, at 11:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1934 to April 23 1944, and that I last saw h[illegible] alive on 4/23 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr

Due to: Arterio Sclerosis — Duration: [illegible]

Due to: Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. F. Moody

Address 1403 Parkave Date signed 4/25/44 M. D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

C 16527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

C 16527

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Wabash Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Cox

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1872

8. AGE: Years 71 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Bavaria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Frank H. Cox
(b) Address 3525 Wabash Ave. 15

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Balto., Md.
Location

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of undertaker) (b) Huntington Williams, Registrar

APR 25 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944, at 2 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Constriction of Trachea

Due to Metastatic carcinoma of breast

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed April 22 1944

G 16528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G 16528 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 N. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

154

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 N. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. GREGORIUS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Birdie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1873

8. AGE: Years	Months	Days	If less than one day
70	7	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Landscape Gardner
11. Industry or business

FATHER
12. Name Christian Jacob Gregorius
13. Birthplace Baden, Germany

MOTHER
14. Maiden Name Rosie Catherine Reddinger
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Bridie M. Gregorius
(b) Address 2111 N. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

APR 25 1944

MEDICAL CERTIFICATION P.

20. DATE OF DEATH April 23, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/43 19 to 4/23/44 19, and that I last saw him alive on 4/23/44 19

Immediate cause of death	Duration
(a) Coronary Thrombosis Generalized Arteriosclerosis	
Due to (b) Chronic Rheumatism	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Harris M.D.
Address 1633 Mount Ave Date signed 4/24/44

G 16529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16529 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Jesse Oliver Chandler

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1887

8. AGE: Years	Months	Days	If less than one day
56	11	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired - Store Operator
11. Industry or business

FATHER
12. Name Robert Chandler
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Miranda --
15. Birthplace Unknown

16 (a) Informant Mrs. Sara Chandler
(b) Address 3810 Norfolk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 25 10 (b) (Date received by registrar) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 12 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944 to April 23 1944, and that I last saw him alive on April 23 1944

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Clifton Lowery, M.D. Address St. Agnes Hosp. Date signed 4/25/44

C 16530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Gr. 16530

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: South Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. South Balt. Gen. Hosp. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Baby Girl Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 21 hr. — min.

9. Birthplace South Balt. Gen. Hosp. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Willis Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Father - W. Wilson
(b) Address 1502 Webster St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-25-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Catonsville, Md.

18 (a) Funeral director Jas L. Stidham
(b) Address 130 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

APR 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1944, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1944 to 4-21 1944 and that I last saw her alive on 4-21 1944.

Immediate cause of death anoxia — Duration —
Due to Cerebral Hemorrhage — —
Due to — —
Other Conditions — —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature George Brooke West Jr. M.D.
Address South Balt. Gen. Hosp. Date signed 4-22-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 16531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 C 16531

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Forest St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 937 Forest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/1914

8. AGE: Years 29 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Richardson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rosa Revels
15. Birthplace Orlando N.C.

16 (a) Informant Rosa Richardson
(b) Address 937 Forest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Barron Connie K. Knight
(b) Address 721 Allequippa St

19 (a) Apr 25 1944 (b)
Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1944 to 4-21 1944 and that I last saw h[illegible] alive on 4-20 1944

Immediate cause of death: Hypertensive Cardio Vascular Disease — Duration 1 Yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 554 Dolphin St Date signed 4-24-44

G 16532 (2) ✓ G 16532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1222

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Eagle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean Braun
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1941

8. AGE: Years 2 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles W. Braun
13. Birthplace md

MOTHER
14. Maiden Name Elsie Haffenstein
15. Birthplace md.

16 (a) Informant Mr. Charles Braun
(b) Address 2226 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3401 Frederick Rd

18 (a) Funeral director John H. Wyatt
(b) Address 4101 Edmondson Ave

19 (a) APR 25 1944 Huntington Williams, M.D. Address St. Agnes Hosp.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 19 44 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 19 44 to 4/22 19 44, and that I last saw h.r alive on 4/22 19 44

Immediate cause of death acidosis — Duration

Due to Vomiting caused by intussusception of

Due to 5 days duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Intussusception of Bowel.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D. Date signed 4/29/44

PHYSICIAN

Underline the cause to which death should be charged in tabulation.

G 16533 ✓ G 16533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Woodbrook Avenue
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Woodbrook Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick H. Donnelly

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife lateMary D. Donnelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1859

8. AGE: Years 85 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Donnelly
13. Birthplace Ireland.

MOTHER
14. Maiden Name Julia O'Connell
15. Birthplace Ireland.

16 (a) Informant Mr John H. Donnelly
(b) Address # 2827 Woodbrook Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 26,1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location # 4300 Old Frederick Road.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) (Date rec'd by registrar) (b) (Registrar)
APR 25 1944 Hunter Van Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 23, 1944 at 3.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941, to April 23 1944.
and that I last saw h. l. alive on April 22 1944

Immediate cause of death Lobar pneumonia — Duration 3 days
Due to
Due to
Other Conditions Hypertensive heart disease Diabetes Stricture
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 539 Fred Ave Date signed 4-24-44

G 16534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

G 16534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Bloom St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Bloom St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA A. GOLDSBOROUGH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John R. Goldsborough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1880

8. AGE: Years	Months	Days	If less than one day
63 62	5 6	19	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Jackson
13. Birthplace

MOTHER
14. Maiden Name Annie Harley
15. Birthplace D. C.

16 (a) Informant John R. Goldsborough
(b) Address 524 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Ffances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) APR 25 1944 Registrar

VS 150 For M. D. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 22, '44 19 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8.19 1942 to 4.22 1944 and that I last saw her alive on 4.15 19 44

Immediate cause of death	Duration
Carcinoma - left breast	2½ yrs.
Due to Cerebral hemorrhage	20 MO
Due to laceration - scalp. fracture - forearm	
Other Conditions due to fall	4.20.44

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Apr 22 1944 at 7:45 M
(c) Where did injury occur? 524 Bloom Street (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Stepped and fell while carrying some clothing down stairs.
23. Signature Rayner Brown M. D.
Address 1500 E. Madison St Date signed 4/24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 16535

450981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16535

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 Etting (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lila Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Norman
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER — 12. Name Vincent Green
13. Birthplace Md

MOTHER — 14. Maiden Name Vanie Green
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto. Md.

18 (a) Funeral director Mt. Frances A. Zeiler
(b) Address 578 W. Biddle st.

19 (a) APR 25 1944 (Date received by registrar) Registrar Hunting & Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 23 1944, at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 1944, to Apr 23 1944, and that I last saw her alive on Apr 23 1944.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Post-operative pneumonia	12 days
Due to: Diabetes mellitus	12 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cenecer
Address J. Hopkins Date signed 4-25

(over)

G 16536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 16536

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Churchton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Offer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 44

8. AGE: Years	Months	Days	If less than one day
			14 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 25 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 APR 25 1944 Huntington Williams, MD
(Date rec'd by registrar) Registrar

VS 150

0895

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21 1944 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 21 1944 to Apr 21 1944; and that I last saw h[illegible] alive on Apr 21 1944

Immediate cause of death respiratory failure — Duration 14 hrs

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp. Date signed 4-22-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 16537 /108

C 16537 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 W. Conway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 W. Conway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Adams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Charlie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1895

8. AGE: Years 48 | Months 8 | Days | If less than one day hr. min.

9. Birthplace St George S C
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Samson Jenkins
13. Birthplace S C

MOTHER 14. Maiden Name Margaret ?
15. Birthplace S C

16 (a) Informant Mable Brown (D)
(b) Address 111 W Conway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory St George S C
Location South Carolina

18 (a) Funeral director Isaiah L. Brown
(b) Address 1028 W Montgomery St

19 (a) (Date received) APR 25 1944 Hunting to Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 11 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944 to 4/24 1944 and that I last saw her alive on 4/23 1944

	Duration
Immediate cause of death Acute Lobar Pulmonary	10 D
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 122 E Lee Date signed 4/25/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G 16538 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wheeler's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ANNIE TURNER SNYDER

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John W. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1853

8. AGE: Years 91 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Turner
13. Birthplace Md.

MOTHER
14. Maiden Name -- Norfolk
15. Birthplace Md.

16 (a) Informant Mr. Herbert T. Snyder
(b) Address 3716 Mohawk Ave., 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) APR 25 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 24, 1944, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Apr 24 1944, and that I last saw her alive on Apr 24 1944

Immediate cause of death: Bronchitis + Influenza — Duration 1 week

Due to:

Due to:

Other Conditions: Old Age Arteriosclerosis — Duration 4 years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Lamb M. D.
Address 1500 Eutaw Pl. Date signed Apr 25

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16539 Registered No.

TH. 85301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Green
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race C
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 13, 1909
8. AGE: Years 35 Months 2 Days 10 9 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name William Green
13. Birthplace Maryland
MOTHER 14. Maiden Name Watlers (D
15. Birthplace Maryland
16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Wm. H. Kelso
(b) Address 1363 Pressman
19 APR 25 1944 (b) Filed by Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1944, at 3:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1943 to 4-22 1944 and that I last saw h.r alive on 4/22 1944
Immediate cause of death: Pulmonary T.B.C. — Duration: 3
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Sanders M. D.
Address BCH Date signed 4/24

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

16540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 16540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4322 Roland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Dr. Arthur Hebb) ARTHUR HEBB

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jeannette Parish Hebb

6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) April 30, 1877

8. AGE: Years 66 | Months 11 | Days 25 24 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name John Stephen Hebb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Louise Heyer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Jeanette Parish Hebb
(b) Address 4322 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) APR 25 1944 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24-44 19 , at 7 15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1944, to 4-24 1944, and that I last saw h alive on 4-24 1944.

	Duration
Immediate cause of death: Hypostatic Pneumonia	2 days
Due to: Cerebral Thrombosis	
Due to: Generalized Arteriosclerosis	
Other Conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel, Jr. M. D.
Address Bon Secours Hosp. Date signed 4-25-44

16541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G 16541 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 Cliftview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Cliftview Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME CARL JOSEPH NICKLES

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 216-01-1258

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Amelia Louise Nickles

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 21, 1889

8. AGE: Years 54 | Months 11 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Furniture Finisher

11. Industry or business

MOTHER / FATHER

12. Name Charles Nickles

13. Birthplace Baltimore, Md.

14. Maiden Name Margaret C. Kroneberger

15. Birthplace Virginia

16 (a) Informant Mrs. Amelia L. Nickles

(b) Address 1405 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) APR 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944, at 6.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1943 to 4/21 1944 and that I last saw him alive on 4/20 1944

Immediate cause of death: Myocardial insufficiency — Duration

Due to: Chronic myocarditis — 5 yrs

Due to: Cardio-renal - vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Sander M. D.

Address 1517 E North Ave Date signed 4/22/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C 16542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

Reg. No. C 16542

FN. 87479

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1164 Cleveland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Lenhardt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20th, 1887

8. AGE: Years 56 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Andrew Lenhardt
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Sterwood
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Wm. Geo. John N. Feinkel's Son
(b) Address 801 W. Fayette St

19 APR 25 1944 (b) Huntingdon Williamsburg, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1944 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944 to 4/23 1944 and that I last saw h. alive on 4/23 1944

Immediate cause of death	Duration
Meningococcic meningitis; Anemia;	7
Due to Sulfathiazine crystaluria; bilateral pyelonephritis	2 years
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr Mans

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seymour
Address 13 CH Date signed M. D. 4/24

G 16543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5212

Registered No. G 16543

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Fleet Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Fleet Ste.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Riser
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife. Roland Riser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1904

8. AGE: Years 40 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name John Schmidt
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Fleborne
15. Birthplace Prince Geo. Co. Md.

16 (a) Informant Mrs. Roland Riser
(b) Address 2604 Fleet Ste

17 (a) Burial (b) Date thereof 4/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Ste

18 (a) Funeral director John B. Connelly
(b) Address 46 Eastern Blvd. Huntington Williamsport, Md.

APR 25 1944
(Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, 2:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to April 24 1944 and that I last saw h[er] alive on April 20 1944

Immediate cause of death: Carcinoma of bladder — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Fleming M.D.

Address 1904 W. Belvedere Date signed 4-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 16544 | BALTIMORE CITY HEALTH DEPARTMENT | C 16544 Registered No.

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Noonan

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-10-7164

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 17, 1885

8. AGE: Years	Months	Days	If less than one day
59		17	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation General Labor
11. Industry or business Seibell Manufacturing Co.

FATHER
12. Name Jeremiah Noonan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kennessy Noonan
15. Birthplace Ireland

16 (a) Informant Miss Elizabeth Noonan
(b) Address 927 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Old Frederick Rd.

18 (a) Funeral director Elmer F. Griffin & Son
(b) Address 2246 E. Eager St.

APR 25 1944 (b) [illegible] Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24-1944, at 12:15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intra-cerebral Hemorrhage
Spontaneous
Due to
Other Conditions Hypertrophy & dilatation of Heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 4-26-44

G 16545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16545

Registered No.

Please write plainly with pen or pencil. Physicians should be careful supply the information requested on this certificate. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 943 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1843

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace A. A. Co. Md (Town, county, and state)

10. Usual Occupation unoccupied

11. Industry or business

FATHER
12. Name Jim Morgan
13. Birthplace A. A. Co Md

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory pt. b. always been
Location A. A. Co. Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1[illegible] Jefferson St

19 (a) APR 25 1944 (Date rec'd by registrar) (b) Hunting to Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944 to 4/23 1944, and that I last saw h[illegible] alive on 4/23 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Uremia + Renal failure	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Glassman, M.D.
Address J. Hopkins Date signed 4-25

G 16546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G 16546 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 923 Fell Street Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Fell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Kempa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Wladyslawa Kempa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1888

8. AGE: Years	Months	Days	If less than one day
56	2	11	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Kempa
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Mrs W Wladyslawa Kempa
(b) Address 923 Fell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) Filed APR 25 1944 Registrar Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944 at 5 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1944 to April 22 1944 and that I last saw him alive on April 22 1944

Immediate cause of death: Hypostatic Pneumonia

Duration: about 2 days

Due to Carcinoma of Prostate gland

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Williams, M.D.

Address 801 N Calvert St Date signed 4/25/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly

C 16547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1087

C 16547 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland or Other Wards
(b) Street address 2820 W North Ave.
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2820 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If so, name country

3 (a) FULL NAME Elsie M. Blare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7-1886

8. AGE: Years 58 | Months 1 | Days 16 | If less than one day min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name F. Elmo. Drury

13. Birthplace Baltimore Md.

14. Maiden Name Ann Rose Dunnington

15. Birthplace Balto. Md.

16 (a) Informant

(b) Address 2820 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26 44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Co. Location E. North Ave

18 (a) Funeral director John C Moran

(b) Address 3600 E Baltimore St Huntington Woods

19 (a) (Date rec'd by registrar) APR 25 1944 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1944, to 4/23 1944, and that I last saw her alive on 4/23 1944

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions Coronary Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Wallerne M. D.

Address 1400 N. Caroline St. Date signed 4/23/44

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

45 P 15548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16548 Registered No. 1222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Colora (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Stanley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-7-27

8. AGE: Years 17 | Months - | Days 18 | If less than one day hr. min.

9. Birthplace PA (Town, county, and state)

10. Usual Occupation Factory Worker

11. Industry or business

FATHER
12. Name Robert Stanley
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Woods
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1944 (month) (day) (year)
(c) Cemetery or crematory Little Britain, Pa
Location Little Britain, Pa

18 (a) Funeral director E. Tyson
(b) Address Bowing Sun, Md.

19 (d) APR 25 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 25 1944, at 102 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 22 1944 to Apr 25 1944, and that I last saw her alive on Apr 25 1944

	Duration
Immediate cause of death: Shock	
Due to: Intestinal Obstruction	
Due to: Adhesions at Ileo-Cecal Valve	
Other Conditions (Include pregnancy within three months of death)	

Date of operation 4/24/44
Major findings of operation: Intestinal Obstruction
of autopsy: Released Intestinal Obstruction

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sloan
Address J.H.H. Date signed 4/25/44

PHYSICIAN
Underline the cause to which death should be charged statis-

correct age is especially important. Physicians: please write the causes of death clearly and legibly

C-16549 BALTIMORE CITY HEALTH DEPARTMENT C 16549
CERTIFICATE OF DEATH 92 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Kroener
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife John Kroener
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 6 - 1870
8. AGE: Years 73 Months 11 Days 17 If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —
FATHER 12. Name Unknown
13. Birthplace "
MOTHER 14. Maiden Name "
15. Birthplace "
16 (a) Informant John Kroener - Husband
(b) Address 1311 Homewood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave
18 (a) Funeral director Kendall E. Cunningham
(b) Address N-01 N. Broadway
19 (a) (Date rec'd by registrar) APR 25 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23-44 19 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 22nd 1944, to 4/21/ 1944. and that I last saw her alive on 19

Immediate cause of death	Duration
Mitral Insufficiency	5 mos.
Due to ------	
Due to -------	
Other Conditions Myocarditis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. W. Hungerford M.D.
Address 401 E. 25th. St. Date signed 4/25/44

G 16550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. G 16550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Knoxville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Herman Deener

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	w	Married

6 (b) Name of husband or wife Daisy L. Cooper
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) June 23 1905

8. AGE: Years	Months	Days	If less than one day
41	3	2	hr. min.

9. Birthplace Maryland
(Town) (County) (State)

10. Usual Occupation Store Dept B&O R.R.
11. Industry or business Transportation

FATHER
12. Name Cornelius C. Deaner
13. Birthplace Maryland

MOTHER
14. Maiden Name Lulu M. Badger
15. Birthplace Maryland

16 (a) Informant C. C. Deaner
(b) Address Knoxville Md

17 (a) Burial (b) Date thereof 4 28 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Lutheran
Location Knoxville Md

18 (a) Funeral director C. N. Zeiler & Bro
(b) Address Brunswick Md

APR 26 1944 (b) Registrar Hunting for Williamsport, Md.

VS 120

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25-44 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-44 19 to 4-25-44 19 , and that I last saw h.i.m. alive on 4-25-44 19

Immediate cause of death Respiratory failure — Duration

Due to Peritonitis from Perforated gastric ulcer

Due to Esophageal-Pleural Fistula

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-10-44
Major findings of operations: Carcinoma of Esophagus
of autopsy: Perforated Gastric ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. V. Latimer, Jr. M. D.
Address Univ. Hosp. Baltimore Date signed 4-25-44

G 16551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 16551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul F Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31st 1940

8. AGE: Years	Months	Days	If less than one day
3	11	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Chas. F. Carter
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Ellen Crayford
15. Birthplace Balto. Md

16 (a) Informant Chas F. Carter
(b) Address 438 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore Md

18 (a) Funeral director F. R. Neubauer, Jr.
(b) Address Baltimore Maryland

APR 26 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 8 1. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-8-44 at 4 P. M. 10/5
(b) Where did injury occur? 438 E. Lanvale St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury He fell out of the third floor window.

23. Signature H. L. Waldenmaier M.D.
Medical Examiner.
Date signed April 24, 1944.

VS 151

G 16552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G 16552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Spedeham Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Chester (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lilly Robert LEO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26, 1935

8. AGE: Years	Months	Days	If less than one day
9	1 0	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Charles Leo Lillie
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lena Gray
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

APR 26 1944 (Date filed) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at 12 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1944 to 4-24 1944 and that I last saw him alive on 4-24 1944.

Immediate cause of death	Duration
cardiac arrest	
Due to diphtheria	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Tracheotomy 4-21
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Savila M. D.
Address Spedeham Hosp. Date signed 4-24

G 16553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16553 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 Longwood Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Longwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Y. Feckting

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clare O. Feckting

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1877

8. AGE: Years	Months	Days	If less than one day
71	9	9	hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual Occupation Eye Surgeon

11. Industry or business Own Business

FATHER
12. Name James A. Feckting
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth McHenry
15. Birthplace Md.

16 (a) Informant Clare O. Feckting
(b) Address 207 Longwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm Cook Son.
(b) Address 1217 St Paul St.

19 APR 26 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24- 1944, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mudd M.D.
Medical Examiner.
Date signed 4-25-44

G 16554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16554 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2343 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2343 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Mueller

3 (b) If veteran, name war: Spanish Am. & World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mollie L. Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1878

8. AGE: Years 65 Months 9 Days 19 If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Charles L. Mueller
(b) Address 910 Bonaparte Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto. Maryland

18 (a) Funeral director William Groff Inc
(b) Address 121 St. Paul St

APR 26 1944 (Date received by Registrar) (b) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1944, at 1A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D. Medical Examiner.
Date signed April 24, 1944.

VS 151

D 16555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

✓ D 16555 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4543 Pimlico Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Baker Everett O. Baker

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katharine M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11 1890

8. AGE: Years 53 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Bradford Mass. Hampshire (Town, county, and state)

10. Usual Occupation Machinery Dealer

11. Industry or business

FATHER
12. Name John F. Baker
13. Birthplace

MOTHER
14. Maiden Name Etta Ayer
15. Birthplace Bradford New Hampshire

16 (a) Informant Katharine M. Baker
(b) Address 4543 Pimlico Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director W. W. E. Zipperle
Address Hilton Chapel Hilltop, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Fair death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull, Compound fracture right leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 26, 1944 12 Midnight
(b) Where did injury occur? Route 103 & Route #1 Ellicott City
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Lee Eastman M.D. Medical Examiner.
Date signed April 26, 1944

APR 27 1944

VS 161

16556 Koren ✓ G 16556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2227 East Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL or give town)
(d) Street No. 2227 East Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Koren

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Sol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Abraham

13. Birthplace Russia

MOTHER 14. Maiden Name Rachel

15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Pikesville Md

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St

19 (a) (Registrar) (b) Huntington Williams, M.D.

APR 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25-1944 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943, to April 1944 and that I last saw her alive on April 23 1944;

Immediate cause of death: General Carcinomatosis — Duration: about

Due to: Carcinoma — 8-9 yrs

Due to: of Breast.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-1936 - 2nd 1943

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature Herman Diesel M.D.

Address 2404 Eutaw Date signed 4/25/44

16557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G 16557
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Springdale Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Sheffield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Clara Jones
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) March 26, 1859

8. AGE: Years	Months	Days	If less than one day
85	--	29	hr. min.

9. Birthplace Long Island, New York
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Edward Sheffield
13. Birthplace R. I.

MOTHER
14. Maiden Name Mary Knowle
15. Birthplace R. I.

16 (a) Informant Anna S. Muse
(b) Address 4207 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

(c) Date received by registrar APR 26 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/ 1944 to 4/19/ 1944, and that I last saw h[illegible] alive on 4/19/ 1944

Immediate cause of death Arterio Sclerotic heart disease — Duration ?

Due to

Due to

Other Conditions Carcinoma of prostate gland
(Include pregnancy within 3 months of death)

Date of operation 3/24/44

Major findings of operation: Chronic recession of prostate gland

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Hogan M. D.
Address 7 E. Preston St. Date signed 4/25/44

C 16558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 172

C 16558 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 S. Eden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Szewczyk

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-1680

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Szewczyk

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Steamfitter

11. Industry or business

FATHER
12. Name Stanislaw
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Anna Szewczyk
(b) Address 232 S. Eden St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr. 27 1944 (month) (day) (yr.)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozdzinski
(b) Address 1930 Eastern Ave.

19 (a) (Date received by local registrar) (b) Hunting for William[illegible] Registrar

APR 26 1944

VS/BC

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24-44 19 44, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions Fractured skull.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-24- at 4:18 P.M. 24/1
(b) Where did injury occur? Harbor, Pier 9 Locust Point
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Found drowned, struck by boom of ship.

Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 4-25-44

G 16559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16559 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 W. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 W. Biddle St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Nathaniel March

3 (b) If veteran, name war

3 (c) Social Security Account No. 144-12-2342

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1893

8. AGE: Years 51 | Months 2 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace N.C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Aaron March
13. Birthplace N.C

MOTHER
14. Maiden Name Unknown
15. Birthplace N.C

16 (a) Informant John Ridcliffe
(b) Address 337 W. Biddle St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park
Location Balto Co

18 (a) Funeral director J. P. Lushbaugh
(b) Address 579 Mosher St

19 (a) APR 26 1944 (b) Huntington Williams, M.D. Registrar

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24/1944 at 7.05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17/1944 to 4/24/1944 and that I last saw h[illegible] alive on 4/23/1944

Immediate cause of death: Lobar Pneumonia — Duration: 7 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Ridcliffe
Address 337 W. Biddle St Date signed 4/25/44

G 16560 — BALTIMORE CITY HEALTH DEPARTMENT — C. 16560

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. Belnord Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Walter J. Wallace (Walas)
3 (b) If veteran, name war
3 (c) Social Security Account No. 200-09-8179

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 7, 1901
8. AGE: Years 43 Months -0- Days 18 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Edw Kelch Transfer Co

FATHER
12. Name George Wallace
13. Birthplace Europe

MOTHER
14. Maiden Name Catherine ?Wojcik
15. Birthplace Europe

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt Stanglaus
Location Baltimore Md
18 (a) Funeral director George A Weber
(b) Address 705 S Ann st
19 (a) APR 26 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944, at 5:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1940, to 4-25 1944 and that I last saw h[illegible] alive on 4-25 1944.

Immediate cause of death	Duration
Cardiac failure	3 mos
Due to Hypertensive cardio vascular disease	4 yrs
Due to Mural thromb[illegible] embolism to legs & lung	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr. Crowe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Mettee M.D.
Address B. C. H. Date signed 4/25/44

PLEASE WRITE IN INK, WITH CAPITAL LETTERS. Physicians: please write the causes of death clearly and legibly. Every question on this record must be answered correctly as far as information can be secured. Cause of death must be stated for every case, but the statement as to manner of death is especially important.

G 16561 HEALTH DEPARTMENT—CITY OF BALTIMORE G 16561

CERTIFICATE OF DEATH

1. PLACE OF DEATH 2117 Dennison Street 11 7 13 1a Registered No.
CITY OF BALTIMORE: (No. The Crawford Retreat St., 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME George Franklin Heybeck If U.S. Veteran specify WAR

(a) Residence: No. 2787 Glendale Road Parkville Ward. Balto. Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Evelyn A. Heybeck

6. DATE OF BIRTH (month, day, year) Nov. 24-1883

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Machinist

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Henry A. Heybeck

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Mollie Demory

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mrs. Evelyn A. Heybeck

(Address) 5201 Fistion Heights Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Druid Ridge Date April 28, 1944

19. UNDERTAKER Burgee Funeral Home

(Address) 3631 Falls Road

20. FILED APR 26 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4-25 1944

22. I HEREBY CERTIFY, That I attended deceased from 4-23- 1944 to 4-25 1944

I last saw him alive on 4-24 1944 Death is said to have occurred on the date stated above, at 7.50 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Oedema of lung. shock	4-20-44
Other contributory causes of importance: Endocarditis, arteriosclerosis of bicuspid valve insufficiency, nephritis	1½ yrs.

Was an operation performed? no Date of

For what disease or injury?

What test confirmed diagnosis? Heart Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Sigmar Pirosh M. D.

(Address) 5202 Wrenth Ave.

SIGMAR PIROSH

OCCUPATION is very important. See instructions on back of certificate.

G 16562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

G 16562 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Kensett St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town B-altimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Kensett St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: Ella J Kane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31 - 1865

8. AGE: Years 78 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Woodlawn Md (Town, county, and state)

10. Usual Occupation Retired Stone Mason

11. Industry or business

MOTHER / FATHER

12. Name John Kane

13. Birthplace Ireland.

14. Maiden Name Catherine Ray

15. Birthplace Ireland

16 (a) Informant Della B. Ferrell

(b) Address 1947 Ridgefield Ave

17 (a) Burial (b) Date thereof April 26-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location Baltimore Md.

18 (a) Funeral director Ingram & Lyles

(b) Address 1600 N. Howard St

19 (a) (b)
(Signature of registrar) Registrar

Hattie Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 11- M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1st 1944 to April 24th 1944.
and that I last saw him alive on April 24th 1944.

Immediate cause of death: Chronic Nephritis a
Uremia

Due to:

Due to:

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 12 days

7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Lehmann M.D.

Address 152 W Mulberry Date signed April 26 1944

G 16563 ✓ G 16563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 Hampson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 14
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Hampson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm H Worthington

3 (b) If veteran, name war: None

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	M

6 (b) Name of husband or wife Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1884

8. AGE: Years	Months	Days	If less than one day
59	4	—	hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Daniel Washington
13. Birthplace Ill

MOTHER
14. Maiden Name unobtainable
15. Birthplace

16 (a) Informant Louise Washington
(b) Address 814 Hampson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Druid Hill Ave

19 (a) APR 26 1944 Hunter [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1944 at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944 to 4/25 1944 and that I last saw h[illegible] alive on 4/[illegible] 1944

Immediate cause of death	Duration
(a) Pulmonary Tuberculosis & Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.
Address 714 Dennison Ave (Date signed)

G 16564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G 16564 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 N. Caroline St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 6 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Jessie) Leslie Jacobs
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-01-4108

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Sarah Jacobs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-1905

8. AGE: Years 38 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Halifax Co. N. C. (Town, county, and state)
10. Usual Occupation Caulker
11. Industry or business

FATHER
12. Name Armstead Jacobs
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth Price
15. Birthplace N. C

16 (a) Informant Sarah Jacobs
(b) Address 6 N. Caroline st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brant Ave

19 (a) APR 26 1944 (Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at 2:05 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-23-44 at 11:47 P. M.
(b) Where did injury occur? Fayette St + Caroline
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature T. F. Wollenweber M.D. Medical Examiner.
Date signed April 24, 1944.

G 16565 87222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 N. Bradford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5th, 1871

8. AGE: Years 73 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER: 12. Name George Lewis
13. Birthplace Maryland

MOTHER: 14. Maiden Name Martha (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentlay ave

19 (a) APR 26 1944 Huntingtown, Md. Address

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1944 at 7 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1944 to 4-23 1944, and that I last saw him alive on 4-23 1944.

Immediate cause of death: Cardiac decompensation — Duration ?

Due to Arteriosclerotic Heart disease — Duration ?

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mahon M.D.
Address Box Date signed 4/25/44

G 16566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16566 Registered No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S. Parrish St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1943
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. PARRISH ST (If rural, give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country GERMANY

3 (a) FULL NAME John J. Neubig

3 (b) If veteran, name war NONE
3 (c) Social Security Account No. NONE

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Christina C. Neubig
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 20-1869

8. AGE: Years 75 | Months 1 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation NONE
11. Industry or business

FATHER: 12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER: 14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant Christina C. Neubig
(b) Address 319 S. Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location City

18 (a) Funeral director Toft & B.M. Walter
(b) Address Toft & Stuckes Sts

19 (a) Date received (Signature of Registrar) Huntington Williams, M.D. Registrar

APR 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944 to 4/24 1944 and that I last saw him alive on 4/24 1944.

Immediate cause of death	Duration
(a) Acute Myocarditis	week
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Foster
Address 402 Edmondson Date signed 4/25/44

452546 C 16567 Dabney C 16567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1952

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E. Pratt St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Josephine Dabney

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-14-07

8. AGE: Years 37 | Months 1 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Md BALTIMORE (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business .....

FATHER — 12. Name Joseph Whittes

FATHER — 13. Birthplace GERMANY

MOTHER — 14. Maiden Name Hattie KOLODZIEYSKI

MOTHER — 15. Birthplace POLAND

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. (month) (day) (year)

(c) Cemetery or crematory STANISLAUS

Location DUNDALK AVE.

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS APR 26 1944 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944 to April 24 1944 and that I last saw her alive on April 23 1944

Immediate cause of death Respiratory failure — Duration .....

Due to Multiple pulmonary infarction — Duration .....

Due to Rheumatic heart disease with auricular fibrillation — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Robert E. Fowler M. D.

Address Johns Hopkins Hosp. Date signed 4/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 16568 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 94a C-16568

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 FAIT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 FAIT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ANDREW P. KRAUS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7 1887

8. AGE: Years	Months	Days	If less than one day
56	10	16	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation STREET CAR CONDUCTOR
11. Industry or business UNITED R.R.

FATHER
12. Name ANDREW KRAUS
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET SCHUTTE
15. Birthplace GERMANY

16 (a) Informant ANNA C? SCHENK (SISTER)
(b) Address 3820 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 27/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler Inc. Undertaking for Williams, M.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 23 19 44 at 6/05 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1924 to April 23 1944. and that I last saw him alive on April 23 1944.

Immediate cause of death: Cirrhosis Embolism — Duration: Sudden 3 hrs.
Due to: Endocarditis ? Mesenteric Thrombosis — Duration: 20 Years
Due to: probably Specific — Duration:
Other Conditions: Resection 2 Months
Mesenteric Thrombosis
(Include pregnancy within 3 months of death)
Date of operation Jan 1944
Major findings of operation: Gangrenous Bowel resected
of autopsy: On Eye.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Milton P. Hall M. D.
Address 4416 Roland Av. Date signed 4/24/44

G 16569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1710a

G 16569
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 E. 41st st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ellen Snee

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 8 1859

8. AGE: Years 85 | Months 1 | Days 17 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name PATRICK SNEE
13. Birthplace IRELAND

MOTHER
14. Maiden Name CATHERINE HIGGINS
15. Birthplace IRELAND

16 (a) Informant ALBERT SNEE (NEPHEW)
(b) Address 1303 GUSRYAN ST.

17 (a) BURIAL (b) Date thereof APR. 26 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location FREDERICK ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) APR 26 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1948 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-24-48 at 10:15 A.M. 9/1
(b) Where did injury occur? Greenmount & 40th sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ---
(d) Means of injury struck by street-car

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 25, 1948

VS 151

G 16570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 16570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 N. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits write RURAL and give town)
(d) Street No. 36 N. Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara J. Dausch.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 10 1881
8. AGE: Years 63 Months 2 Days 14 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business
FATHER 12. Name Joseph Miller
13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Carrie Osterman
15. Birthplace Balto. Md.
16 (a) Informant Lawyer
(b) Address 36 N. Lakewood.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (day) (year) Apl 27 44
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.
18 (a) Funeral director Thos. A. Williams
(b) Address 3110 E. Balto. St.
19 (a) (Signature of registrar) (b) Hunting for Williams, M.D.

APR 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at 3:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944, to April 24 1944, and that I last saw her alive on April 24 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 hours
Due to: Hypertension — 10 yrs.
Due to: Arteriosclerosis — 10 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Michael J. Dausch M. D.
Address 2530 E. Baltimore St. Date signed 4-25-44

G 16571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Gr. 16571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Riverside Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Riverside Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0851

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1883

8. AGE: Years	Months	Days	If less than one day
60	5	19	20 hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)

10. Usual Occupation Ship Carpenter

11. Industry or business Retired

FATHER — 12. Name John Wm. Tucker

13. Birthplace Md.

MOTHER — 14. Maiden Name Rosie M. Smith

15. Birthplace Md.

16 (a) Informant Mrs. Bertha Everaman

(b) Address 1615 Belt st. (sister)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)

(c) Cemetery or crematory Glen Hill Cem.

Location A.A. Co. Md.

18 (a) Funeral director P. J. Howard Evans

(b) Address 1400 E. Chase St. (Balto 30, Md.)

19 (a) APR 26 1944 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

spontaneous

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Featherston M.D. Medical Examiner.

Date signed April 26 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No. G 16572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2720 Belvedere ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hatch

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1852

8. AGE: Years	Months	Days	If less than one day
62	2	23	hr. min.

9. Birthplace Anne Arundel Co., Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business –

FATHER
12. Name Charles Hatch
13. Birthplace Md.

MOTHER
14. Maiden Name Charity ?
15. Birthplace Md.

16 (a) Informant William Hatch
(b) Address 2001 Madison Avenue

17 (a) Burial
(Burial, cremation, or removal) (b) Date thereof 4-28-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore County Md

18 (a) Funeral director Wallace & Jacobs
(b) Address 1416 Pennsylvania Ave

19 (a) APR 26 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25- 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Welsh M.D.
Medical Examiner.
Date signed 4-25-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16573

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G 16573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3434 Mt. Pleasant Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3434 Mt. Pleasant Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (or) Hattie Hedwig (or) Hattie Tuepal (or) Tenpal (or) Tepel

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26 1850

8. AGE: Years 84 | Months 4 | Days 29 | If less than one day: hr. min. 1860

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home.

11. Industry or business

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ? Kubinski
15. Birthplace Germany

16 (a) Informant Augusta Lippert
(b) Address 3434 Mt. Pleasant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dyer & Sons
(b) Address Maryland Ave & 25th Sts.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 26 1944 Hunter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944 at 10:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20, 1944, to 4-25, 1944, and that I last saw h[illegible] alive on 3-20-44 19

Immediate cause of death Arteriosclerosis Cerebral
Due to General Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
M. D.

Address 734 S. Conkling St. Date signed 4-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16574

Registered No. 398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 547 W. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 547 W. Mosher St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Sydnor

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Mrs Iver Sydnor

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1893

8. AGE: Years 60 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Lancaster Co Va (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Schmidts Bakery

FATHER
12. Name Spencer Sydnor
13. Birthplace Va

MOTHER
14. Maiden Name Mary Jan Bean
15. Birthplace Va

16 (a) Informant Mrs Iver Sydnor
(b) Address 547 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)
(c) Cemetery or crematory Huntsville Ala
Location

18 (a) Funeral director Mrs Katie B Williams
(b) Address 322 N Schroeder St

19 (a) APR 26 1944 Registrar

VS 150

Huntsville Williams, Mgr

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1944 at 10:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1944 to 4-23 1944. and that I last saw him alive on 4-27 1944.

Immediate cause of death	Duration
Broncho pneumonia	3 days
Due to Influenza	9 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 4-24-44

G 16375

BALTIMORE CITY HEALTH DEPARTMENT G 16525 Registered No.

CERTIFICATE OF DEATH 33a

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 776 W. Lanvale St
(c) Hospital or institution:
(d) ~~Length~~ of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 776 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? R (Yes or No)
If yes, name country

3 (a) FULL NAME Laurie Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Chas Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Private
12. Name Unknown — FATHER
13. Birthplace "
14. Maiden Name Unknown — MOTHER
15. Birthplace "
16 (a) Informant Bessie C Wilson
(b) Address 761 W. Mulberry St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 320 N Schroeder St
19 (a) APR 26 1944 (Date rec'd by registrar) (b) Registrar

VS 150

Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/44 11:40 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/20/44 to 4/22/44, and that I last saw her alive on 4/20/44

Immediate cause of death: Bronchopneumonia — 3 days

Due to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Carl Williams M. D.
Address 501 Md Ave D

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 16576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 16576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1945 Lauretta Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 Lauretta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Kenney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Peyton Kenney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1865

8. AGE: Years 78 | Months 11 | Days — | If less than one day hr. min.

9. Birthplace Lottesburg Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Herman E. Burgess
13. Birthplace Va

MOTHER 14. Maiden Name Margaret Gordon
15. Birthplace Va

16 (a) Informant Virgie Menges
(b) Address 1945 Lauretta Ave

17 (a) Burial (b) Date thereof 4-28-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lottsburg
Location Lancaster Co. Va

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 150

Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18/ 1944 to 4/20/ 1944
and that I last saw her alive on 4/22/44 1944

Immediate cause of death Cerebral Thrombosis — Duration

Due to Myocarditis Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Havill M. D.
Address 600 N. Carrollton Ave Date signed 4/26/44

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 16577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G 16577 Registered No.

Write the causes of death clearly and legibly. Physicians please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Old Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (Cherry Hill) (If outside city or town limits write RURAL and give town)
(d) Street No. 3301 Old Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F M	W	Widowed

6 (b) Name of husband or wife Frederich H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1872

8. AGE: Years	Months	Days	If less than one day
71	11	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name Joseph Real
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Slaughter
15. Birthplace Md

16 (a) Informant Mrs Mildred Gardiner
(b) Address 3301 Old Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 380 N Frederick Ave

18 (a) Funeral director William M Marech
(b) Address 715 Light St

19 (a) Filed APR 26 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 10:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 19XX to Apr 24 1944, and that I last saw h alive on Apr 24 1944.

Immediate cause of death	Duration
Hemorrhage	2 days.
Due to Mitral Regurgitation	Indef
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Harlem Date signed 4/25/44

16578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G 16578 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 W. Saratoga
(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Elizabeth Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	S

6 (b) Name of husband or wife W
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-24-44

8. AGE: Years	Months	Days	If less than one day
		1 2	hr. min.

9. Birthplace 1110 W. Saratoga (Town, county, and state)
10. Usual Occupation no
11. Industry or business no

FATHER
12. Name Allen Catlin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dorothy Jones
15. Birthplace Baltimore Md

16 (a) Informant Dorothy Jones
(b) Address 1110 W Saratoga

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory ✓
Location UNIVERSITY MEDICAL SCHOOL APR 26 1944
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) APR 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1944, at 1 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1944 to 4-26 1944 and that I last saw h alive on 4-25 1944.

Immediate cause of death A Asphyxia — Duration 1 Day
Due to
Due to ✓
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature B. N. Halpern
Address 1111 E Pratt Date signed 4-26-44

VS 150

0900

16579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 16579

Registered No. 1610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hosp.
(c) Hospital or institution:
Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto;
(c) City or town Baltimore
(If outside city or town, insert RURAL and name town)
(d) Street No. Church Home & Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Pfeffer
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: infant

6 (b) Name of husband or wife none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 19, 1944

8. AGE: Years | Months | Days: 6 5 | If less than one day: hr. min.

9. Birthplace Church Home & Hospital
(Town, county, and state)

10. Usual Occupation infant
11. Industry or business none

FATHER
12. Name Edmund Pfeffer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mamie Kwiatkowski
15. Birthplace Clarksburg, W. Va.

16 (a) Informant mother
(b) Address 703 N. Lakewood Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 26 1944 (Date received by Registrar) Hunter for Williams M.D. Registrar

VS 150

0898

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944, to April 24 1944, and that I last saw her alive on April 24 1944.

Immediate cause of death: Atelektasis L LL
" RLL
Due to
Due to
Other Conditions jaundice,
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Church Home & Hospital Date signed 4/25/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16580 Registered No. 1321a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Hanover St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No. 117-05-7837

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Pearl Castle

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 8/7/1874

8. AGE: Years 69 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Night watchman

11. Industry or business Bakery Co.

FATHER — 12. Name Charles Gardner
13. Birthplace Germany

MOTHER — 14. Maiden name Barbara Wachter
15. Birthplace Germany

16 (a) Informant Pearl Gardner
(b) Address 3819 Edmondson Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Catonsville Highway

18 (a) Funeral director Chas. E. Shepherd & Sons
(b) Address 318 Light St.

19 (a) (Date rec'd) APR 26 1944 (Registrar's signature) Hunting to Williams, Jr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20/ 1944, to 4/25/ 19 44
and that I last saw h... alive on 4/23/ 19 44.

Immediate cause of death: Influenzal pneumonia — Duration: 4 or 5 days

Due to

Due to

Other Conditions: Hypertensive cardio vascular renal disease. ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Castle
1226 Hanover St. Date signed 4/26/ 1944.
M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16581 Registered No. 104a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5140 Wright ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Agnes Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 1, 1943

8. AGE: Years | Months: 11 | Days: 24 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John T. Jones
13. Birthplace Md

MOTHER
14. Maiden Name Agnes George
15. Birthplace Md

16 (a) Informant John T Jones
(b) Address 5140 Wright Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-1944 (month) (day) (year)
(c) Cemetery or crematory Oakdale Lawn
Location Eastern Ave Road

18 (a) Funeral director Leo G. Cook
(b) Address 701-23 N. Patterson Park

19 (a) Date received by registrar APR 28 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25-1944, at 5:30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uffer Respiratory Infection

Due to

Other Conditions Edema - Congestion of lungs. Hemorrhagic Adenomas.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 4-25-44

C 16582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

C 16582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Arabia Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Arabia Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah M.Banks

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race Wht.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry P.Banks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.13,1855

8. AGE: Years 89 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Isiah Taylor
13. Birthplace England

MOTHER
14. Maiden Name Hannah Cox
15. Birthplace Ohio

16 (a) Informant Geo. C.Philpot
(b) Address 4506 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 APR 27 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH April 24 1944, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1943, to April 24 1944 and that I last saw her alive on April 23 1944.

Immediate cause of death Fracture of right femur — Duration 4 days
Due to Epithelioma of breast — 6 years
Due to
Other Conditions Generalized arteriosclerosis — Unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence April 24 at 5.45 A.M.
(c) Where did injury occur? Balto. City Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fell out of bed

23. Signature George Dillman
Address 4808 Harford Rd Date signed 4/27/44

VS 2

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16583 BALTIMORE CITY HEALTH DEPARTMENT G 16583 Registered No.

CERTIFICATE OF DEATH

137a

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Springhill ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harris Schapiro

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Ida
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1874
8. AGE: Years 70 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Solomon Schapiro
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam Schapiro
15. Birthplace Russia

16 (a) Informant Mrs. Esther Miller
(b) Address 2806 Springhill ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Hebrew Rest
Location Bowleys Lane
18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave
19 APR 27 1944 (Date rec'd by reg.) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26-44 1944, at 1:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-16-44 1944, to 4-26 1944, and that I last saw h.wife alive on 4-26 1944

Immediate cause of death	Duration
Cerebrovascular accident	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-21-44
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lyscom J. Lyon M. D.
Address Sinai Hospital Date signed 4-25-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 16584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3321 Belvedere Av. #15
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alma B. Steele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Arthur W.

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1891

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Joshua Shelly
13. Birthplace md.

MOTHER
14. Maiden Name Rebecca Tarbell
15. Birthplace Penna.

16 (a) Informant Arthur Steele
(b) Address 3321 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Zion Prs. Church
Location Sparks, Md.

18 (a) Funeral director Sanders M. Dowty
(b) Address Govd. Williams

19 (a) APR 27 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1944, to April 26 1944, and that I last saw h.e.r. alive on April 26 1944.

Immediate cause of death

Duration

Hypostatic pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Herman Wilkins M. D.
Address Md. Gen. Hosp. Date signed April 26, 1944

G 6585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G 165 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Hollins St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Kaufman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1884

8. AGE: Years 62 | Months — | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name Christian Kaufman
13. Birthplace Germany

MOTHER
14. Maiden Name Jennie Mc Connell
15. Birthplace England

16 (a) Informant David Kaufman
(b) Address 1120 Hollins St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof April 28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director L. A. Hilgenberg, Sons
(b) Address Baltimore, Maryland

APR 27 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1944 to April 26 1944 and that I last saw him alive on April 26 1944.

Immediate cause of death Carcinoma, Head — Duration

Due to the Tumor —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Carcinoma Papillary

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. S. Ingraham M. D.
Address Univ. Hospital Date signed April 26 44

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and fully.

16586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. C 16586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or the word "unknown" inserted. Information should be carefully supplied, as the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E 28th St - 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles William Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Elizabeth Cook 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19th 1885

8. AGE: Years	Months	Days	If less than one day
58	7	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Supervisor moving & storage
11. Industry or business Davidson Transfer Co

MOTHER / FATHER
12. Name William Jacob Cook
13. Birthplace Maryland
14. Maiden Name Angie Kraft
15. Birthplace Maryland

16 (a) Informant Mrs Elizabeth Cook
(b) Address 324 E. 28th St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Bork Inc
(b) Address 1217 St. Paul St

19 4/27/44 Huntington Williams, M.D. (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1944, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944 to 4/26 1944 and that I last saw h/m alive on 4/25 1944.

Immediate cause of death: Cardio Resp. failure — Duration

Due to Uremia

Due to Carcinoma of Prostate or bladder c extension

Other Conditions Through to pelvis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. N. Crosby
Address Mercy Hosp. Date signed 4/27/44

16587 G 16587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1626 Jackson st (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ellen C. Moler

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Robert E. Moler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1884

8. AGE: Years	Months	Days	If less than one day
55	2	3	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Charles L. Childress
13. Birthplace Va

MOTHER
14. Maiden Name Alice Salmon
15. Birthplace Va

16 (a) Informant Robert E. Moler
(b) Address 1626 Jackson st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) May 1 1944 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

Correct age is especially important. Questions 9, 10, 11, 12, 14, 16 must be answered.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25/44 19 , at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22/44 19 , to 4/25/44 19 , and that I last saw her alive on 4/25/44 19 .

Immediate cause of death	Duration
Uremia	5 days
Due to Impalpensive C. V. Disease	4 years
Due to Nephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Collins Flinch M. D.
Address Franklin Square Hosp Date signed 4/26/44

16588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G 16588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont & Madison
(c) Hospital or institution:
Md. General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, print RURAL and give town)
(d) Street No. 1321 W. 42nd St. #11 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Edward S. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Mary O. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1880

8. AGE: Years 63 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation engineer

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Jacob L. Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Selma Menchey
15. Birthplace Carroll Co. Md.

16 (a) Informant Miss Selma A. Smith
(b) Address 1321 W. 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) 4/27/44 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1944, to April 26 1944, and that I last saw h[illegible] alive on April 26 1944.

Immediate cause of death	Duration
Carcinoma of liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Herman Walkins M. D.
Address Md. Gen. Hosp Date signed April 20, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16589
70-82206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12B

✓ G 16589 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 10mos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Derby Manor Drive (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Woolery
3 (b) If veteran, name war W
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife Ida (d)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 7, 1869
8. AGE: Years 74 Months 8 Days 18 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Christopher Woolery
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Shriver
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Md.
18 (a) Funeral director Wilborn Stock Inc.
(b) Address 1217 E. Fond St.
19 (a) 4/27/44 (b) (Filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944, at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1944 to 4/25 1944, and that I last saw him alive on 4/25 1944

Immediate cause of death: Acute [illegible] ; pulmonary TBC.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Sorgman
Address BCH Date signed 4/29

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16590 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto City Jail
(b) Street address 901 Buren St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore. T. Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar-22-1924

8. AGE: Years 20 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Laurence Thomas
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Carrie Baltimore
15. Birthplace Virginia

16 (a) Informant Mary Claborne Crawford mother
(b) Address 1169 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks & Co
(b) Address 1443 Carey St

19 (a) APR 27 1944 (b) Huntington Williams M.D.
(Act of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944 at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4/1943 to 4/25 1943 and that I last saw h alive on Apr 25 1944

Immediate cause of death: Pulmonary tuberculosis — Duration 3 mths

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Matt Murphy M.D.
Address 801 Buren St Date signed 4/25/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G 16591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G 16591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1523 Rutland
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar A. P. Mouth

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Era Mouth (59)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 19, 1870

8. AGE: Years 74 | Months — | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Oscar Mouth
13. Birthplace Germany

MOTHER
14. Maiden Name Don't Know
15. Birthplace Germany

16 (a) Informant Era Mouth
(b) Address 1522 Rutland Ave

17 (a) Cremation (b) Date thereof 4/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 3008 Reisters St

19 (Signature) Huntingtown, Williamsport, Md
APR 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 24 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944, to 4/24 1944, and that I last saw h alive on 4/24 1944

Immediate cause of death Pneumonia
Due to Edema

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
1 D
14

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oscar Mouth
Address Date signed 4/26/44

correct age is especially important. Physicians: please write the

G 16592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G 16592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES KREESE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1942

8. AGE: Years 1 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name William Kreese
13. Birthplace Germany

MOTHER
14. Maiden Name Edna Stemmer
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Edna Kreese
(b) Address 3213 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Orleans St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

APR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 1944, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1944, to 4-24 1944, and that I last saw him alive on 4/24 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to —

Due to —

Other Conditions Hydrocephalus congenital
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Partial autolysis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Weisskopf M.D.
Address Sinai. Hosp. Date signed 4-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16593 ✓ 927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eberhard J. Albers / Albers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Katherine Albers.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 29, 1878

8. AGE: Years 65 | Months 9 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Albers
13. Birthplace Germany

MOTHER
14. Maiden Name Elsie Von Segen
15. Birthplace Germany

16 (a) Informant Katherine Albers
(b) Address 3306 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) ____ (b) ____

(Date received by Local Registrar) APR 27 1944 Huntington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at ____ M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertension
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 26, 1944

G 16594 ✓ X G 16594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

478

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 Admiral Blvd
(c) Hospital or institution: 40 Admiral Blvd St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(c) Street No. 40 Admiral Boule
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Michael Suttka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Suttka

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jul 12, 1883

8. AGE: Years 60 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Prussia (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

MOTHER / FATHER

12. Name Michael Suttka

13. Birthplace Prussia

14. Maiden Name Mary Von Kolish

15. Birthplace Prussia

16 (a) Informant Catherine Suttke

(b) Address 40 Admiral Boulevard

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Apr 29 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Ridge

Location Washington Boulevard

18 (a) Funeral director Wilbur Funeral Home

(b) Address 2004 E. Orleans

19 (a) (Date received by registrar) (b) Registrar

Verified Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1944, to 4/26 1944, and that I last saw him alive on 4/26 1944

Immediate cause of death Pulmonary Edema

Due to Carcinoma of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. E. Williams M.D.

Address 1400 N. Caroline St Date signed 4/26/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16595 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1833 Hope Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Hope Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida S. Robinson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elmer E. Robinson
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 21st., 1865

8. AGE: Years: 78 | Months: 11 | Days: 5 | If less than one day: ##### min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER: 12. Name: John Evans
13. Birthplace: Baltimore, Md.

MOTHER: 14. Maiden Name: Mary Evans
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Pearl Burns (Daughter)
(b) Address: 1833 Hope Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/29/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: east End of North Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date rec'd by Registrar) (b) Huntingtown, Williams, M.D.
APR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1944, at 6 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-1944, to 4-26-1944, and that I last saw h alive on 4-24-1944.

Immediate cause of death: Cardio-renal-vascular disease — Duration: 1/5/44
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Vera Barden
Address: 1517 E. North Ave. Date signed: 4/26/44
Balto. Md. 13.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

16596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16596 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 - Forrest St
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Lubbard St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Bradle

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henrietta Bradle
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 2 | 15 | 1900

8. AGE: Years 44 | Months 3 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Washington, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name David Bradle
13. Birthplace Washington, N. C.

MOTHER
14. Maiden Name Sarah Fallston
15. Birthplace Washington, N. C.

16 (a) Informant Henrietta Bradle
(b) Address Cambridge, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30/44 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Cambridge, Md

18 (a) Funeral director Lewis H. Bayne
(b) Address Cambridge, Md

19 APR 27 1944 (Date filed by registrar) [signature] Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944 at 4:32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944, to April 26 1944, and that I last saw h[illegible] alive on ____, 19__.

Immediate cause of death: Respiratory obstruction — Duration
Tuberculous Laryngitis
Due to: Pulmonary tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. T. Kamm, M. D.
Address Md. Penitentiary Date signed 4-26-44

16597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

✓ G 16597

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL T. ROEDER

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-05-9180

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Louise S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1868

8. AGE: Years 75 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Doctor of Medicine

11. Industry or business

FATHER
12. Name Samuel T. Roeder
13. Birthplace Pa.

MOTHER
14. Maiden Name Rachel O. Nizer
15. Birthplace Md.

16 (a) Informant Miss Beulah Roeder
(b) Address 1904 E. Fayette St. 31

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) APR 27 1944 (Signature of registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1943 to April 26 1944 and that I last saw h alive on April 26 1944

Immediate cause of death: Chronic Myocarditis

Duration: 1 yr

Due to

Due to

Other conditions: Cirrhosis Tuberculosis Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Richardson M.D.

Address 112 W. 25th St Date signed April 27 1944

correct age is especially important. Punctuate: please write the causes of death clearly and legibly.

G 16598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G 16598 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2868 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY BRAUL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1866

8. AGE: Years	Months	Days	If less than one day
77	6	3	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -- Homberg
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Wm. H. Braul
(b) Address 3320 Ravenwood Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Registrar) (b) Huntington Williams M.D.

APR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-1937, to 4-25-1944, and that I last saw her alive on 4-22-1944

Immediate cause of death Uremia
Arteriosclerotic cardio-renal disease

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Ehrhart M. D.
Address 2802 Harford Ave. Date signed 4-26-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~44 16599~~ G 16599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Sparrows Pt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 C St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ralph Glazier (Ralph Clark Glazier)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-23-75

8. AGE: Years 68 | Months 11 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace PA (Town, county, and state)

10. Usual Occupation Supt. Coke Oven Dept.

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name George Glazier
13. Birthplace Mass

MOTHER
14. Maiden Name Mary E Clark
15. Birthplace Mass

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) APR 27 1944 (b) Registrar Hartley H. Hillcoat, M.D.

VS 150

correct age is especially important... typewriting, please write...

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 25 1944, at 7.33 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1944, to Apr 25 1944, and that I last saw him alive on Apr 25 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Massive Pulmonary Embolus	
Due to Thrombophlebitis, lower extremities, bilateral	8 wks.
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.....

23. Signature Wm. B. Spencer III. M. D.
Address Johns Hopkins Hosp. Date signed 4-26-44

G 16600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 16600 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Purlington Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Settle (Charlotte Sanger Settle)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Norman C. Settle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1892

8. AGE: Years 52 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace Ohio (Norwood)
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Jesse Sanger
13. Birthplace Mass.

MOTHER
14. Maiden Name Charlotte O'Malley
15. Birthplace Maryland

16 (a) Informant Mr. Norman C. Settle
(b) Address 5206 Purlington Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 27 1944 (a) Date rec'd by Registrar (b) Huntington Willard, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25/44 19 , at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24/ 1944, to 4/25/44 and that I last saw her alive on 4/25/44 19

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-	
Due to Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address Agnes Hosp. Date signed 4/27/44

G 16601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

G 16601

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS Sterling FRAZIER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1876

8. AGE: Years	Months	Days	If less than one day
67	8	8	hr. min.

9. Birthplace Reisterstown, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Thomas Jefferson Frazier
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Knight
15. Birthplace Reisterstown, Md.

16 (a) Informant Mr. Guy Frazier
(b) Address 2128 N. Fulton Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Hen[illegible]

APR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 44, at 12 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carbon monoxide poisoning

Due to Suicide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-26-44 at M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury Gas heater in bathroom
23. Signature W. D. W. Allen Jr. M.D. Medical Examiner.
Date signed 4-26-44

16602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G 16602

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S. Lakewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 441 N. Kenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JOSEPH WERNIG

3 (b) If veteran, name war ----- | 3 (c) Social Security Account No. ------

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/42

8. AGE: Years 2 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Joseph Wernig
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Clara Zaworski
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Clara Wernig
(b) Address 441 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski's Sons
(b) Address 1808 Eastern Ave.

APR 27 1944 (Registered by registrar) Huntington-Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944, at 9.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1943, to 4-25 1944, and that I last saw [illegible] alive on 4-25 1944

Immediate cause of death: Acute Leukemia — Duration of illness

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Gallod M. D.
Address 707 E. Fort Ave. Date signed 4-26-44

VS 150

Fill in all items by typewriter if possible. Otherwise write the causes of death clearly and legibly.

16603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16603
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/26/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 2/26/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Hazel Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER HOCKINS HOLT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1877

8. AGE: Years 66 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Salisbury, Md. (Town, county, and state)

10. Usual Occupation Master

11. Industry or business Barge Frank Munich 9

FATHER
12. Name Alfred A. Holt
13. Birthplace Seaford, Del.

MOTHER
14. Maiden Name Henrietta Somers
15. Birthplace Fairmont, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-44 (month) (day) (year)
(c) Cemetery or crematory Parson Cemetery
Location Salisbury Maryland

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury, Maryland
(c) Date received by registrar APR 27 1944
Huddington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26, 1944 to Apr. 26, 1944, and that I last saw h im alive on Apr. 26, 1944

Immediate cause of death Bronchogenic carcinoma, right lung with extensive metastases — Duration Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 4/26/44

MS-51295

16604 G 16604

BALTIMORE CITY HEALTH DEPARTMENT

JO #67417 **CERTIFICATE OF DEATH** 448 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Fowler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1908

8. AGE: Years 35 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Fowler
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Earley
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 19 44 to 4/22 19 44
and that I last saw h[illegible] alive on 4/22 19 44

Immediate cause of death Pulmonary Edema — Duration ?
Due to Anemia, Post Hemorrhagic — ?
Due to Leukemia, Lymphogranuloma — ?
Other Conditions — ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mathews M. D.
Address B. C. H. Date signed 4/27/44

G 16605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G 16605 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Fenhan ave
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Overland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. Papania

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) March 1, 1896

8. AGE: Years	Months	Days	If less than one day
48	1	25	hr. min.

9. Birthplace New Orleans, La.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name John Papania
13. Birthplace Italy

MOTHER: 14. Maiden Name Anita Garlasio
15. Birthplace Italy

16 (a) Informant Mrs Grace Papania
(b) Address 2806 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J Rost
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) APR 27 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26- 1944 at 10 27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1944 to 4-26 1944, and that I last saw him alive on 4-26 1944

Immediate cause of death Pancreatitis Necrosis — Duration

Due to Subtotal Gastrectomy

Due to Gastric Ulcer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-21-44

Major findings of operation: Penetrating pyloric ulcer

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Young Jr. M. D.
Address Md Gen. Hosp Date signed 4-26-44

G 16606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry McAntosh

3 (b) If veteran, name war None.

3 (c) Social Security Account No. 218-03-4775

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edna

6 (c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) 4/7/1896

8. AGE: Years 48 | Months - | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace B. H. L. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name John McAntosh
13. Birthplace B. H. L.

MOTHER
14. Maiden Name Henrietta
15. Birthplace B. H. L.

16 (a) Informant Edna McAntosh (Wife)
(b) Address 1132 Druid Hill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md.

18 (a) Funeral director Charles G. Corbin
(b) Address 512 W. Carrollton Ave

19 (a) 4-27-1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 4:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollenweber M.D. (Medical Examiner.)
Date signed April 24th, 1944.

16607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16607

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rhea Armstrong

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1874

8. AGE: Years 69 66 | Months 4 3 | Days 26 | If less than one day 1 hr. 17 min.

9. Birthplace Maryland
(Town, county, or state)

10. Usual Occupation Adjuster

11. Industry or business

FATHER
12. Name James Armstrong
13. Birthplace Maryland.

MOTHER
14. Maiden Name Catherine Bunton
15. Birthplace Maryland.

16 (a) Informant Mrs. Rhea Armstrong
(b) Address 1224 N. Calvert St. Apt 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 505 N. Calvert St.

19 (a) (Date received) (b) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1944, at 1:47 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to April 26 1944 and that I last saw deceased alive on April 26 1944

Immediate cause of death Coma — Resp. failure — | Duration 5 Hours
Due to Uremia | 24 hours
Due to Chronic Nephritis | ?
Other Conditions Diabetes — Gangrenous Rt. leg. | ?
(Exclude pregnancy within 3 months of death)
Date of operation 4-12-1944
Major findings of operation: Gangrenous st. leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul R. Ziegler M. D.
Address Mercy Hosp Date signed 4-26-44

16608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G 16608

1. PLACE OF DEATH:
(a) City or County: Baltimore City, Maryland
(b) Street address: 2901 Winden Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 D
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2901 Winden Av. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Alice M. Dreschsler

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robt. J.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15-1894

8. AGE: Years: 50 | Months: 1 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Balto. Md (Town, county and state)

10. Usual Occupation: Housework

11. Industry or business:

FATHER
12. Name: Thos. J. Gill
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Catharine Roach
15. Birthplace: Maryland

16 (a) Informant: Robt. J. Dreschsler
(b) Address: 2901 Winden Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/28/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto Md

18 (a) Funeral director: George A. Farley
(b) Address: Fulton & Fayette

19 APR 27 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1944, about 6-60 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1944 to 4/25 1944, and that I last saw h[illegible] alive on 4/24 1944

	Duration
Immediate cause of death: Uraemia	48 hrs
Due to: Chr. Nephritis	6 mos
Due to:	
Other Conditions: Arthritis	6 mos

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: M. J. Wiedenmatt

Address: 1136 Poplar Grove St. Date signed: 4/26/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

16609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G 16608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Celestine McLoughlin (Sarah McLoughlin)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1867

8. AGE: Years 77 | Months — | Days 2 | If less than one day hr. min.

9. Birthplace Philadelphia, Penna (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Daniel McLoughlin
13. Birthplace County Down, Ireland

MOTHER
14. Maiden Name Elizabeth Nesbitt
15. Birthplace Lisburn, Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 27 44. (month) (day) (year)
(c) Cemetery or crematory Mount Hope Cemetery
Location Mount Hope Retreat, City

18 (a) Funeral director Stewart & Monroe Company
(b) Address 102-W-North Avenue, City

19 (a) APR 27 1944 [illegible]

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944, to April 26 1944, and that I last saw her alive on April 26 1944

Immediate cause of death: Left Cerebral Hemorrhage 3 days

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian A. Magica M. D.
Address 3316 Auchentoroly Ter. Date signed

E 16610 | BALTIMORE CITY HEALTH DEPARTMENT | G 16610
Registered No.

CERTIFICATE OF DEATH

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Warden St (If rural give location)
(e) Citizen of-foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores C. ~~Thomas~~ Thommen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ~~Leo Thomas~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1941

8. AGE: Years 2 | Months 6 | Days 29?8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Francis W. Thommen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth E. Baptiste
15. Birthplace Baltimore Md.

16 (a) Informant Francis W. Thommen
(b) Address 1019 Warden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Md

18 (a) Funeral director Flynn & Flannigan
(b) Address 1426 Light St.

19 (a) APR 27 1944 (Date received by Registrar) (b) Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 11 P.M. 45

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to hes death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock Trauma

Due to Fractures of pelvis multiple

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/26/44 at 10/1 5:45 P.M.
(b) Where did injury occur? Chase & Warden Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
(d) Means of injury Pedestrian struck by auto

23. Signature by auto Wm. Williams M.D. Medical Examiner.

Date signed 4-27-44

C 16611 C 16611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. 451374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 550 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest King Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	Sep.

6 (b) Name of husband or wife Rachel Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-93

8. AGE: Years	Months	Days	If less than one day
50	-	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name James Cooper
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Preston
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Cir. A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) APR 27 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 22 1944 to April 23 1944 and that I last saw h[illegible] alive on April 23 1944

Immediate cause of death	Duration
Terminal pneumonia of left lung	3 days
Due to Plasmacyt Bronchus 16 days after R2 pneumectomy	16 days
Due to Actinomycosis of right lung.	years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-5-44
Major findings of operation: Rt. lung sclc. inflam.; actinomycosis of lung
of autopsy Anatomical Diag. 4/24/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Brumback Jr.
Address Johns Hopkins Hospital Date signed 4/25/44

correct age is especially important. Physicians: please

G 16612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V117a

G 16612 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 Druid Hill Ave
(c) Hospital or institution: Baltimore Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Ruter St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Steadley

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M

5. Color or race Aa

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Oneel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/1906

8. AGE: Years 37 Months 6 Days 18 If less than one day hr. min.

9. Birthplace Denmark S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Willie Steadley

13. Birthplace S.C.

MOTHER 14. Maiden Name Chiefy Hooker

15. Birthplace

16 (a) Informant Oneel Steadley

(b) Address 1314 Ruter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 27 1944 (month) (day) (year)

(c) Cemetery or crematory Denmark, S.C.

Location

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1517 Druid Hill Ave.

19 (a) APR 27 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24/1944, at 2 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12/1944, to 4/25/1944 and that I last saw him alive on 4/24/1944.

Immediate cause of death Chronic suppurative Peritonitis

Due to Perforation of appendix

Due to Constipation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 1943

Major findings of operation: Perforated gangrenous appendix + abscess

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. B. Higgins M. D.

Address President Hosp. Date signed 4/27/44

correct age is especially important. Physicians: please write the

VS 150

G 16613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16613 Registered No. 120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Woodland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3316 Woodland Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jerome L. Nixon,

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5564

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine Nixon
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 29, 1878

8. AGE: Years	Months	Days	If less than one day
65	9	25	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business Gas & Electric Co.

FATHER
12. Name John Nixon,
13. Birthplace Ireland

MOTHER
14. Maiden Name Sally Dignan,
15. Birthplace Ireland.

16 (a) Informant Mrs. Catherine Nixon,
(b) Address 3316 Woodland Ave.

17 (a) Burial (b) Date thereof 4/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City.

18 (a) Funeral director Le Vern e Lemmon,
(b) Address 4611 Park Heights Ave.

19 (a) APR 27 1944 (b) [illegible] Williams, M.D.
Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944 at 6.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944 to 4/24 1944, and that I last saw him alive on 4/24 1944.

Immediate cause of death Acute Nephritis — Duration 3/4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh D. Beebert M.D.
Address 4803 Park Heights Date signed 4/26/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 16614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C 16614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] E. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Frances Sisko

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Semain A. Sisko
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1905

8. AGE: Years: 38 | Months: 5 | Days: 9 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Stanislaw Wyzalkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Pinkowska
15. Birthplace Poland

16 (a) Informant Mrs. Helen Wirds
(b) Address 410 E. Lundell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welker
(b) Address 401 S. Chester Street

19 (a) [illegible] (b) Huntington Williams M.D.

APR 27 1944

VS 161

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944, at 11.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Necrosis of pancreas and

Due to Stab wound of back

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 25 1944 4 P.M.
(b) Where did injury occur? 216 E. Cross St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 26, 1944

G 16615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Use the word "None" or the letters "NA" where there is no entry, or the item is unknown. Do not abbreviate. Give the usual name of occupation of each person, even if retired. Also the kind of work done during most of working life, even if for only a few years. Be sure to answer each question. Where there is a choice of words, underline the correct one. Information is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1665 Chilton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1665 Chilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Scott.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John E. Scott.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8-1889

8. AGE: Years 54 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home work.

11. Industry or business

FATHER
12. Name Andrew Fiedler
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Loeffler
15. Birthplace Germany

16 (a) Informant Mrs Charles Scott
(b) Address 618 Dulaney Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor Ave

18 (a) Funeral director Wm H. Valentine
(b) Address 2326 Aisquith St.

19 (a) (b) (Signature and address of undertaker) Hilleary MD

Apr 27 1944 Vs

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1943 to April 26 1944 and that I last saw h[illegible] alive on April 26-7 P.M.

Immediate cause of death Chronic Myocarditis — Duration 5 Months 2 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. C. Link. M. D.
Address South Baltimore Date signed April 26 1944

G 16616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G 16616
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 Mt. Pleasant Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or suburbs, write RURAL and give town)
(d) Street No. 3420 Mt. Pleasant Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie R. Ely.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Female	Colored	Married	George A.	79 years

7. Birth date of deceased (mo., day, yr.) Sept 13-1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	7	12		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business "

FATHER
12. Name John. Sander
13. Birthplace Md.

MOTHER
14. Maiden Name John. Hybeart
15. Birthplace Md.

16 (a) Informant George A. Ely
(b) Address 3420 Mt. Pleasant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl. 27-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John. J. Mahon
(b) Address Bon & Balto. Md.

19 (a) (Date rec'd by registrar) APR 27 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1944 to 4/25 1944, and that I last saw h CY alive on 4/22 1944.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Ely
Address 3215 Eastern Ave Date signed 4/27/44 D.

G 16617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 S. Clinton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. O'Neill

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary O'Neill

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.): July 29-1891

8. AGE: Years 52 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace: Balto.
(Town, county, and state)

10. Usual Occupation: Baltimore Transit Co

11. Industry or business:

FATHER
12. Name: Andrew J. O'Neill
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Devar
15. Birthplace: Canada

16 (a) Informant: Mary O'Neill
(b) Address: 203 S. Clinton Ave

17 (a) Burial (b) Date thereof: April 29-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: New Cath.
Location: Old Frederick Rd

18 (a) Funeral director: John J. Ryan
(b) Address: 3609 E. Baltimore

19 (a) APR 27 1944 (b)
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute cardiac failure

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 26, 1944

To the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

G 16618 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 Ridgewood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Bouis.

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife: Wilhelmina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1912

8. AGE: Years	Months	Days	If less than one day
31	7	14	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Glen L. Martin Co.

FATHER
12. Name Clarence G. Bouis
13. Birthplace Md.

MOTHER
14. Maiden Name Hattie E. Moore.
15. Birthplace Washington, D. C.

16 (a) Informant Mr. C. M. Bouis D. C.
(b) Address 2227 - 20th St., N. W., Wash.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Rock Creek Cem.
Location Wash., D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) APR 27 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1944 at 2 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2-1944 to 4-26 1944 and that I last saw h[illegible] alive on 4-26 1944

Immediate cause of death: Septicemia, (5 days).

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-8-44

Major findings of operation: Perforated Peptic Ulcer

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Macdonald

Address 1213 Light St Date signed 4-26-44

G 16619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16619 163H Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Bloomingdale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Ursula Glorius (S.T.)

3 (b) If veteran, name war

3 (c) Social Security Account No. None.

MEDICAL CERTIFICATION 8:15

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1895

8. AGE: Years 48 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Brookburg Maryland
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Mt. Hope Retreat

FATHER
12. Name William A. Glorius
13. Birthplace Maryland

MOTHER
14. Maiden Name Celia Byrnes
15. Birthplace Ireland

16 (a) Informant Durst's Funeral Home
(b) Address Frostburg, Md.

17 (a) Burial (b) Date thereof Apr. 27 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Michaels
Location Frostburg, Md.

18 (a) Funeral director Wm. J. Trikner & Son
(b) Address North St. Ta Ares.

19 (a) (Date rec'd by registrar) Transit to Williamsport

VS 181 27 1944

20. DATE OF DEATH April 26, 1944, at P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to Mental Dependency

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-26-44 at 7:20 P. M.
(b) Where did injury occur? 1905 Bloomingdale Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Carbon Monoxide Poisoning

23. Signature J. J. Wallenmeyer M.D.
Medical Examiner.
Date signed April 27, 1944. Kitchen stove

Write the causes of death clearly and legibly. Use only standard terminology. Do not use abbreviations or symbols. Do not state mode of dying, such as heart failure, asphyxia, anemia, uremia, etc. Do not write "Old Age" as the cause of death. Indicate duration of each cause. Fill in items 20 to 23, inclusive, and sign certificate. Physicians: please write correct age in items 8 and 9. Information in items 10 to 15, inclusive, is especially important.

G 16620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 16620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 N. North Avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Pirosh

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dr. Sigmar Pirosh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/21/1882

8. AGE: Years 61 | Months 11 | Days 6 | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Jacobson
13. Birthplace Lithuania

MOTHER
14. Maiden Name Pauline Mendelsonn
15. Birthplace Russia

16 (a) Informant Mrs. Robert Pirosh
(b) Address 2202 N. North Ave

17 (a) Cremation (b) Date thereof April 27, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address N. + Ra ave.

19 (a) APR 27 1944 (b) Washington Hill, Md. Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 44 at 10:10 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture, compound, right tibia & fibula.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-27-44 at 9:30 A. M.
(b) Where did injury occur? 2202 N. North Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Fell from her front porch.

23. Signature H. Z. Wollenmeber M.D.
Medical Examiner.
Date signed April 27, 1944.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16621 / 83a

Registered No. G 16621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Datterwich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Dalzyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Sebastian
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fisher
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 944 Greenmount Ave

19 (a) (registrar) (b) Huntington Williams, M.D.

APR 27 1944

VS 150

MEDICAL CERTIFICATION

8 p.

20. DATE OF DEATH April 25 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1944, to April 25 1944, and that I last saw him alive on April 25 1944.

Immediate cause of death — Duration

Edema Lungs — 1 day

Due to: Cerebral Hemorrhage — 2 day

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E. North Ave. Date signed 4/26/44

G 16622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16622 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME E. Burlington Gill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie Vaughn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace md

MOTHER
14. Maiden Name Margaret Crowther
15. Birthplace md

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29 1944 (month) (day) (year)
(c) Cemetery or crematory St Stephens
Location Bradshaw, Md

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave.

19 (a) APR 27 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION 9.4m

20. DATE OF DEATH April 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to April 27 1944, and that I last saw him alive on April 26 1944

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic myocarditis	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 4/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 16622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Burgundy St.
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Burgundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Block

3 (b) If veteran, name war W

3 (c) Social Security Account No. NIHE

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Bertha Block

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21st 1870

8. AGE: Years 74 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Block
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Madeline Fleck
(b) Address 2008 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto Md

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

APR 28 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25th 1944 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1944 to 4-25 1944, and that I last saw him alive on 4-25 1944

Immediate cause of death: Acute Cardiac Failure — Duration 1 Dy

Due to: Cardiovascular Renal Disease — 5 yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Lawrason M. D.

Address 679 Washington Blvd Date signed 4/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G 16624 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Chrisa A. Lewis

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6th 1866

8. AGE: Years 77 | Months 11 | Days 6 20 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Moses Lent
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Holland
15. Birthplace "

16 (a) Informant Nellie Lewis
(b) Address 202 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St

19 (a) APR 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Address 644 Hanover

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1944, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944, to Apr 26 1944, and that I last saw h[illegible] alive on Apr 25 1944.

Immediate cause of death	Duration
Acute dilatation of heart	24 hr.
Due to arteriosclerosis	[illegible]
Due to Mitral Regurgitation	[illegible]
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation?
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Date signed 4/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

6 16625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 47c ✓

G 16625 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. #4 Seven Mile Lane
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse J. Hyatt

3 (b) If veteran, name war: W

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mrs. Jesse J. Hyatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1882

8. AGE: Years 61 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation Railroad Engineer

11. Industry or business B&O Railroad

FATHER
12. Name Louis Hyatt
13. Birthplace Maryland

MOTHER
14. Maiden Name Lou Brevard
15. Birthplace Maryland

16 (a) Informant admission History
(b) Address Union Mem Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Balto Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 2125 Pinkard

19 APR 28 1944 (b) Registrar Hunting for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 12 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1944 to 4-27 1944 and that I last saw h.i.m. alive on 4-27 1944

Immediate cause of death: Cardio-Respiratory Failure — Duration: ?

Due to: Bronchiogenic Carcinoma

Due to:

Other Conditions: Arterio-sclerotic Heart Disease — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Bronchiogenic Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Hunting Jr. M. D.
Address 332 E. University Pkwy. Signed 4/27/44

G 16626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 16626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Hollen Rd
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Hollen Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannah P. Norris

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband William T. Norris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1894

8. AGE: Years 49 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business U.S. Public Health Service

FATHER 12. Name Joseph E. Delaney

13. Birthplace Md

MOTHER 14. Maiden Name Catherine Hubbard

15. Birthplace Md

16 (a) Informant Wm T. Norris

(b) Address 718 Hollen Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)

(c) Cemetery or crematory U.S. National

Location Balto. Md

18 (a) Funeral director William Cox Inc.

(b) Address 1217 St. Paul st.

19 APR 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1944, at 4 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1942 to April 26 1944, and that I last saw h.... alive on April 25th 1944.

	Duration
Immediate cause of death: Cerebral hemorrhage	21 hours.
Due to Cerebral arteriosclerosis	3 years.
Due to Hypertension.	8 years.
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. L. Shelpant M. D.
Address 6210 York Road Baltimore 12 Date signed April 27 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G 16627 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 Eutaw Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Eutaw Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna R Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robt. M.

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Aug 8-1900

8. AGE: Years 43 | Months 8 | Days 16 17 | Less than one day hr. min.

9. Birthplace Balto. Md. (town, county, and state)

10. Usual Occupation Saleswoman

11. Industry or business

FATHER 12. Name Samuel A. Stewart

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Lehigh

15. Birthplace Md

16 (a) Informant Ruth M. Stewart

(b) Address 617 Eutaw Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 44 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location E. North Av.

18 (a) Funeral director Charles A. McGann

(b) Address 3011 E. Baltimore St.

APR 28 1944 (Date rec'd by registrar) (b) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to Apr 25 1944, and that I last saw h[illegible] alive on April 25 1944.

Immediate cause of death Carcinoma of Lung - Dyst — Duration 1942

Due to [illegible]

Due to

Other Conditions Trauma — 1944

(Include pregnancy within 3 months of death)

Date of operation 1943

Major findings of operation: Carcinoma of Lung

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 501 Hunter Av. Date signed 4-26-44

G 16628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16628 ✓ 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Brune St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melinda Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace "

16 (a) Informant Mr Allen Parker
(b) Address 519 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (Signature) Registrar

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24/44, at 8.00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Nephritis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh T. McHall M.D. Medical Examiner.
Date signed 4-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 466

G 16629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 E Monument st
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1181 S. Eaton st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Obertier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation
11. Industry or business Conf House

MOTHER / FATHER
12. Name Jisel Obertier
13. Birthplace Russia
14. Maiden Name Sophie ?
15. Birthplace Russia

16 (a) Informant Mrs Oscar Klupt
(b) Address 3625 Rosedale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 28/44 (mo.) (day) (yr.)
(c) Cemetery or crematory Holy Rosedale
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

VS APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1944 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1944 to 4-27 1944, and that I last saw him alive on 4-27 1944.

Immediate cause of death	Duration
Adynamic ileus	
Due to Operation on 4-21-44	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-21-44
Major findings of operation: Infiltrating ulcerocarcinoma of sigmoid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tyson J. Tyson M. D.
Address Sinai Hospital Date signed 4-27-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16630 Registered No. 94a

13-1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Hurwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Gerson Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Evelyn ?
15. Birthplace Russia

16 (a) Informant Harry Hurwitz
(b) Address 2501 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1944 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1943 to 4/27 1944 and that I last saw her alive on 4/27 1944

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions: Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence Chidsey M. D.

Address 2225 Tenderen Date signed 4/27/44

Interview Williams, M.D.

G 16631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16631

91a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Elizabeth Johns

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married —

6 (b) Name of husband or wife Irwin H. Johns
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 16 1927

8. AGE: Years	Months	Days	If less than one day
16	7	169	..... hr. ..... min.

9. Birthplace Wilson, N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Griffin
15. Birthplace North Carolina

16 (a) Informant Mrs. Neal Devan
(b) Address 902 W. Fayette Street

17 (a) Burial (b) Date thereof 5-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director William H. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) ..... (b) ..... Huntingtown, Md.
(Date received by registrar)

APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25- 1944, at 7:10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH .....
Subacute Bacterial Endocarditis
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Cheslin M.D.
Medical Examiner.
Date signed 4-25-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. G 16632 — BALTIMORE CITY HEALTH DEPARTMENT — V G 16632

CERTIFICATE OF DEATH

58c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs. 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edmond Scott (EDWIN)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1938

8. AGE: Years	Months	Days	If less than one day
-6-	-3-	15	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Zeke Scott
13. Birthplace South Carolina

MOTHER — 14. Maiden Name Hettie Chestnut
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial, cremation, or removal (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location A. A. County, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 28 19 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1944, at 5:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1944 to 4/27 1944 and that I last saw h[illegible] alive on 4/27 1944

Immediate cause of death Pneumonia, Uremia, Hypocarditis — Duration 5d.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. F. Seyman M.D.
Address BCH Date signed 4/27

G 16633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16633

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 840 George St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 840 George St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Millie Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 Months Days If less than one day hr. min.

9. Birthplace S C, (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name George Hefner

13. Birthplace S.C.

MOTHER 14. Maiden Name Lenia Pickett

15. Birthplace S C

16 (a) Informant Mildrinia Wilmore

(b) Address 840 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-44 (month) (day) (year)

(c) Cemetery or crematory Rock Hill S C

Location S C

18 (a) Funeral director Elmer O Wilson

(b) Address 1000 Granby St

19 (a) APR 28 1944 (Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944, to 4/27 1944, and that I last saw him alive on 4/27 1944

Immediate cause of death Chronic Cardio-vascular Renal disease — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 4/28

G 16634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 16634 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Prospect Circle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Prospect Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HELEN M. BROWN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richard Thomas Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 17, 1865

8. AGE: Years 79 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER: 12. Name: William Snow Stuart
13. Birthplace: Rochester, N. Y.

MOTHER: 14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Miss Irene Stuart Brown
(b) Address: 4506 Prospect Circle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) APR 28 1944 (b) Filed

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 to 4/25 1944, and that I last saw h[illegible] alive on 4/25 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 10 days
Due to: Arteriosclerosis — 5 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Norman A. Todd, M. D.
Address: 735 N. Fulton Av. Date signed 4/27/44

G 16635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16635 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Guilford. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy White Shaffer.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0661

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1884

8. AGE: Years 59 | Months 9 | Days 26 | If less than one day hr. min. 16

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Vice President

11. Industry or business Carey Sales & Service

FATHER
12. Name James F Shaffer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sally S Kinner
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Clara Shaffer (wife)
(b) Address 2912 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) (Registrar)

APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to April 1944, and that I last saw him alive on March 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic heart disease	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M.D.
Address 205 N Rolling Rd. Date signed 4-26-44

G 16636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 16636 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Borish (MYER JESSE BORISH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 43 Months Days If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Store Keeper

11. Industry or business

MOTHER | FATHER

12. Name Not Known

13. Birthplace Russia

14. Maiden Name Paulene

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Pikesville Hamilton Ave

18 (a) Funeral director Jack Levinson

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington, W. Virginia, A

APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 6.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 24 1944, to Apr. 27 1944, and that I last saw him alive on Apr. 27 1944.

Immediate cause of death: Cardio-respiratory failure — Duration:

Due to: Cerebral Hemorrhage

Due to: Malignant Hypertension — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dmark

Address Sinai Hosp Date signed 4/27 D.

Dr Davidson
3218 Eastern Ave

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16637 (93)

Registered No. G 16637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 Huntingdon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Thomas.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife: Gregory Thomas
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nick Alexakos.
13. Birthplace Greece.

MOTHER
14. Maiden Name Garfalia Papahanas
15. Birthplace Greece.

16 (a) Informant Peter L. Thomas.
(b) Address 6900 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44. (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 2615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) APR 28 1944 (b) Huntingdon Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1944 at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1943, to April 27 1944. and that I last saw h[illegible] alive on April 5 1944.

Immediate cause of death	Duration
Chr. Myocarditis	?
Due to Chr. Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature N. J. Davidson M. D.
Address 3218 Eastern Ave Date signed 4-28-44

16638

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

G 16638

Registered No. 16182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and name town)
(d) Street No. Wilson Trailer Camp
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virgil Dwight Sheffey

3 (b) If veteran, name war — 3 (c) Social Security Account No. None

4. Sex Male — 5. Color or race White — 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-44

8. AGE: Years 51 — Months — Days 4 — If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Claude Sheffey
13. Birthplace Va.

MOTHER — 14. Maiden Name Edith Taylor
15. Birthplace Va.

16 (a) Informant Claude Sheffey
(b) Address Wilson Trailer Camp Halethorpe

17 (a) Burial (b) Date thereof 4-28-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westview Pk.
Location Westview Park Co.

18 (a) Funeral director Wilson Cook Dec. Co.
(b) Address 1219 E. Cold Spg.

APR 28 1944 (Registrar) Huntingtown Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 (hour) 1944 to 4/27 (hour) 1944 and that I last saw h[illegible] alive on 4/27 (hour) 1944

Immediate cause of death: Septicemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Kaffenberger M.D. M. D.

Address St. Agnes Hosp. Date signed 4/27/44

correct age is especially important. Physicians: please w[illegible]

G 16639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4611 Cedar Hollow Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

1 (a) FULL NAME GEORGE W. BELT

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-24-0031

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isabell Harvey

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1891

8. AGE: Years 53 Months 3 Days 3 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Glen L. Martin

FATHER 12. Name George W. Belt

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Rosa Battenfelf

MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Kenneth D. Belt

(b) Address Marine Barracks, Quantico

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md.

18 (a) Funeral director Thos. Nelson & Son

(b) Address 2503 Edmondson Ave.

(a) (b) Williams Mgr. Registrar

(Date rec'd by registrar) APR 28 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1944 3:20 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cellulitis, right arm

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-24-44 Glen L. Martin M.

(b) Where did injury occur? Middle River Balto.

(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? Yes

(d) Means of injury Splinter in thumb.

23. Signature H. L. Wollenmiller M.D. Medical Examiner.

Date signed 4-27-44

640 AB

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16640
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Mae Gladney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6-1907

8. AGE: Years	Months	Days	If less than one day
37	-	18	hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Sterling
13. Birthplace ?

MOTHER
14. Maiden Name Martha Ann Rosser
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Atlanta
Location Georgia

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3224 Belvedere Ave.

APR 28 1944
(Date rec'd by registrar)
Huntington Williams M.D.
Registrar

VS 150

PLEASE WRITE PLAINLY, with pen and ink. Do not use pencil. Do not abbreviate. Write the causes of death clearly and correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1944, at 5:30 A

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1944 to 4/14 1944 and that I last saw h alive on 4/17 1944.

Immediate cause of death	Duration
(a) Pneumonia;	
(b) Pulmonary Embolism;	
(c) Coronary Occlusion	two d.
Due to	
Due to	
Other Conditions Anemia; Disseminated Lupus Erythematosus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy: Obstruction - final diagnosis Embolism

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Sergeson M. D.
Address BCH Date signed 4/25

PHYSICIAN
Underline the cause to which death should be charged statistically.

16641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 16641
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Essie Slater

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Benjamin Slater
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1904

8. AGE: Years 40 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Elvey
13. Birthplace Manticoke Md

MOTHER
14. Maiden Name
15. Birthplace S.C.

16 (a) Informant Benjamin Slater
(b) Address 515 N. Stricker St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St.

19 APR 28 1944 (Date received by registrar) Kate R. Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1944, 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1944 to April 24 1944, and that I last saw her alive on April 24 1944.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Bonsell M.D.
Address Provident Date signed 4/28/44

PLEASE WRITE PLAINLY, with pen and ink. Fill in all items. Be sure to state the causes of death clearly and legibly. Do not use abbreviations or symbols. Be sure to give correct age in each case. Physicians: please write the cause of death in such a way as to make it especially important.

16642 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 131a G 16642

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 Argyle a St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Milliane Chambers

If U. S. Veteran specify WAR

(a) Residence: No. 1319 argyle a St., Ward. 17 2

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Chambers

6. DATE OF BIRTH (month, day, year) 1874

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Wilmington Delaware

FATHER

13. NAME Unknown.

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Mamie Houston

(Address) 1319 Argyle Ave.

18. BURIAL, CREMATION, OR REMOVAL Place Mt Auburn Cem. Date 4/28 1944

19. UNDERTAKER Mrs Kate Dw Selligman

(Address) 322 N Schroeder St

20. FILED APR 28 1944 Huntington Williams, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Apr. 25 1944

22. I HEREBY CERTIFY, That I attended deceased from Apr. 4 1944 to Apr. 25 1944

I last saw h[illegible] alive on Apr. 23 1944 Death is said to have occurred on the date stated above, at 9:15 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio-Vascular Renal	2

Other contributory causes of importance: Arteria Sclerosis

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Edward J. Headley M. D.

(Address) 238 Smallwood Ave

MAKE ENTRIES ON BACK. See instructions on back. OCCUPATION is very important.

G 16643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G 16643 Registered No.

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2541 Penna. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 Penna. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie S. Steal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Frank A. Steal
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1872

8. AGE: Years 71 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic work
11. Industry or business

FATHER 12. Name Patrick Finn
13. Birthplace Ireland

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Frank A. Steal
(b) Address 2541 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 | 1 | 44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Martin Gahan & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b)

APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1944, at 3 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to April 26 1944.
and that I last saw h[er] alive on April 25 44

Immediate cause of death
Cardiac Renal Insufficiency
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Three hours
4 years
Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred B Jewett M. D.
Address 2546 Penn Ave Date signed April 27/44

Attested by Howard J. Wessels, M.D.

16644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 16644

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dalbert 33-16

(c) Hospital or institution Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d.

(e) Length of stay in Baltimore (yrs., mos., or days) 90yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Catonsville, Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 2-2 Carter's Convalescent Home (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Jane Noll

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex F.

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1853

8. AGE: Years 90 Months 4 Days 7 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Standiford

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Mrs. Maude N. Weld

15. Birthplace ?

16 (a) Informant Mrs. Maude N. Weld

(b) Address 1606 Chilton St., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 28 44 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location York-Pa.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. MOWEN SUC.) 108 N. NORTH AVENUE

19 (a) APR 28 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 12 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1944, to April 27 1944, and that I last saw h[illegible] alive on April 27 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	18d.
Due to Senility - general debility	yrs.
Due to Traumatic fracture 2 pt. femur	18d.
Other Conditions Arteriosclerotic heart disease - Cerebral hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 4-9-44 at M

(c) Where did injury occur? Carter Convalescent Home (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)

(e) Means of injury Slipped in bath-room

23. Signature Glenn O. Bratt M. D.

Address Union Memorial Date signed 4/27/44

Approved by Howard J. Weidler, M. D.

Please write the causes of death clearly and legibly. Physicians: please note that correct age is especially important.

G 16645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16645 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3118 Windsor Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Windsor Ave (If rural give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Sauers

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John H. Sauers
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Jan 20 1860

8. AGE: Years 84 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

MOTHER / FATHER

12. Name Frederick Laufer

13. Birthplace Germany

14. Maiden Name Could not ascertain

15. Birthplace Germany

16 (a) Informant Mr. Geo. J. Sauer (son)
(b) Address 3118 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Jos. Jordens & Son
(b) Address 1927 Park Ave.

19 (a) APR 28 1944 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1941, to April 26 1944, and that I last saw her alive on April 26 1944:

Immediate cause of death: Chronic Myocarditis — Duration 4 yrs.

Due to: Arteriosclerotic Cardiovascular Renal Disease

Due to:

Other Conditions: Diabetes Mellitus Amputation of Rt Thigh
(Include pregnancy within 3 months of death)

Date of operation 1941

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward H. Nolan M.D.
Address 1331 E. Northave Date signed 4-27-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 16646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 E

Registered No. G 16646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6211 DANVILLE AVE.
(c) Hospital or institution:

26-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6211 DANVILLE AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY P. WIEDECK

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARY C. WIEDECK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 6 1888

8. AGE: Years 55 | Months 6 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation PUMP OPERATOR

11. Industry or business STANDARD OIL

FATHER
12. Name FREDERICK WIEDECK
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA KOERNER
15. Birthplace GERMANY

16 (a) Informant MARY C. WIEDECK (WIFE)
(b) Address 6211 DANVILLE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 29/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lillyard Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) APR 28 1944 (Date received) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 25 19 44 at 4/15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 19 44 to Apr 25 19 44, and that I last saw h[illegible] alive on Apr 24 19 44.

Immediate cause of death: Generalized Lymphosarcoma — Duration: Abt 4/13

Due to:

Due to: — Duration: over

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eva Schemmerhorn M. D.
Address 942 Eastern Date signed 4-27-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 16647 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Balto Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Argyle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY STROUT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Geo B. Strout

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 - 1886

8. AGE: Years 57 | Months | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr Emmel
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director D. L. Conaughton
(b) Address 21 N 15 St.

19 (a) APR 28 1944 (Date received by local registrar) (b) Hunting to Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1944, to 4/27 1944, and that I last saw h[illegible] alive on 4/27 1944.

	Duration
Immediate cause of death: Cardio respiratory failure	
Due to Ca of breast	
Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Ca of breast

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Lederer, M.D.
Address Sinai Hospital Date signed 4/27/44

G 16648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1321a

G 16648 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4621 Harcourt Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4621 Harcourt Rd (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Florence G. Lambdin

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Charles E. Lambdin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26- 1861

8. AGE: Years	Months	Days	If less than one day
82	3	30	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Reuter
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Walker
15. Birthplace Md.

16 (a) Informant Chas. E. Lambdin
(b) Address 4621 Harcourt Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-28-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rogers Ave

18 (a) Funeral director Leo O Cook
(b) Address 1701-03 Eutaw Pl Ave

19 (a) APR 28 1944 (Date rec'd by registrar) (b) Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944 at 6.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1944 to April 25 1944; and that I last saw her alive on April 25 1944.

Immediate cause of death	Duration
Bronchopneumonia	3d.
Marked coma	4d.
Due to Arterio Sclerosis	4y
Hypertension	4y
Due to Chronic Interstitial Nephritis	4y.
Other Conditions Renal Degeneration	4y.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature I. F. O Storms
Address 2878 Hartford Rd Date signed 4-26-44 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16649 ✓ G 16649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No.

G 16649

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 752 Edgewood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 752 Edgewood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Weitzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Ella M. nee Howes 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 1875

8. AGE: Years	Months	Days	If less than one day
68	7	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business

FATHER
12. Name Henry Weitzel
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Helene Lips
15. Birthplace Germany

16 (a) Informant Mrs. Ella M. Weitzel
(b) Address 752 Edgewood St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4-29-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Henry H. Weibke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

APR 28 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to April 27 1944, and that I last saw him alive on April 26 1944.

Immediate cause of death	Duration
Laryngeal + Pulmonary Tuberculosis	Several Yrs
Due to	
Due to	
Other Conditions Tertiary Syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Mitchell M. D.
Address 290 Edmondson Date signed April 28 1944

G 16650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16d
(e) Length of stay in Baltimore (yrs., mos., or days) 14yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 E W Litlock St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hugh Douglas McClarren

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/44

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name William Otto McClarren
13. Birthplace Atlanta, Ga.

MOTHER
14. Maiden Name Frances Justine Horsey McClarren
15. Birthplace Petersburg Va

16 (a) Informant Mrs. F. Justine McClarren
(b) Address 111 E Whitlock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. A. Holland
(b) Address 1651 Druid Hill Ave.

19 (a) (b)

APR 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25/44 19 , at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944, to 4/25 1944, and that I last saw h/l alive on 4/23 19 44.

Immediate cause of death: Atelectasis — Duration 2 days

Due to

Due to

Other Conditions: Work Jetsam.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Atelectasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Louise Jones M. D.
Address 1100 Druid Hill Ave Date signed 4/27/44

Please write the causes of death clearly and accurately. Physicians: please write the correct age as especially important.

G 16651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 Cliftview Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1644 Cliftview Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MARGARET WASSMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles Wassman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1860

8. AGE: Years	Months	Days	If less than one day
83	6	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George Hohman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Neumann
15. Birthplace Germany

16 (a) Informant Miss Rosie Hohman
(b) Address Augsburg Home

17 (a) Burial (b) Date thereof 4/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthew's
Location Baltimore, Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 1008 Orleans St.

19 (a) Huntington-Williams, M.
(Date rec'd by registrar)
APR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944 19 at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 43 to Apl 26 19 44 and that I last saw her alive on Apl 25 19 44

Immediate cause of death — Duration

Hypertensive Cardio Vascular Disease — 1 yr

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J Kinzey M. D.
Address 3780 Harford Road Date signed Apl 27 1944

G 16652
AB-87658

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93c

G 16652
Registered No.

"PLEASE WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Ernest Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. ?-1870

8. AGE: Years 74 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Stokes
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Lehigh Cemetery
Location O'Donnell St

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1637 E. Baltimore St. Funeral Home Baltimore, Md.

APR 28 1944 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1944 to 4-27 1944 and that I last saw h / alive on 4-27 1944

Immediate cause of death: Cardiac Decompensation — Duration ?

Due to Rheumatic cardiac vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mattern M. D.

Address B. C. H. Date signed 4/27/44

G 16653

452065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 442

G 16653 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Hereford (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 Lincoln Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Evelyn M. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-07

8. AGE: Years 36 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation teacher

11. Industry or business

MOTHER / FATHER

12. Name John P. Miller

13. Birthplace Pa.

14. Maiden Name Gwendolyn Geeca Craven

15. Birthplace Pa.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Removal - Burial (Burial, cremation, or removal) (b) Date thereof Apr 28-1944 (month) (day) (year)

(c) Cemetery or crematory St. Bernards

Location Indiana, Pennsylvania

18 (a) Funeral director Burger Funeral Home

(b) Address Main & Falls Road Huntingtown Williamsport Md.

APR 28 1944 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1944 to April 27 1944 and that I last saw him alive on April 27 1944.

Immediate cause of death: Respiratory failure — Duration: 3 mos

Due to Hodgkin's Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. B. Miller III M. D.

Address Johns Hopkins Hosp Date signed 4-29-44

VS 150

16654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95 B

Registered No. 6-16654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Curtis Bay
(If outside city or town limits write RURAL and give town)
(d) Street No. 1519 Filbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Mea MILLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Clyde Miller
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) July 17th 1904

8. AGE: Years 39 | Months 9 | Days 9 | (If less than one day) hr. min.

9. Birthplace Grant, Kentucky
(Town, county, and state)

10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Sam Allen
13. Birthplace Kentucky

MOTHER
14. Maiden Name Cynthia Hicks
15. Birthplace Kentucky

16 (a) Informant Mr Clyde Miller
(b) Address 1519 Filbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Mineral Cem.
Location Route #2 Wheelersburg Ohio

18 (a) Funeral director John F Kenney Inc
(b) Address 715 Light St

19 (Date received) APR 28 1944 (Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944 at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1944 to 4/26 1944; and that I last saw her alive on 4/26 1944.

Immediate cause of death: Rheumatic heart disease.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Macdonald M. D.
Address 1213 Light St Date signed 4-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be typewritten or made with indelible pencil. Do not use abbreviations except where indicated. Be sure to answer each question. If unknown or if question is not applicable, write "unknown" or "N. A." Do not leave any blanks. Be particularly careful to see that the cause of death is stated in such terms as to show clearly the disease, if any, which originated the fatal train of morbid conditions, or in the absence of disease, the violence which produced death, and that the statement of the cause of death clearly and legibly. Use only standard terminology, and do not use symptoms alone as the cause of death. Indefinite or unsatisfactory terms, such as "cardiac failure," "heart disease," "pneumonia," "senility," "uremia," "convulsions," "hemorrhage," "shock," "exhaustion," "paralysis," "tuberculosis," "cancer," "abscess," "septicemia," "blood poisoning," "malignancy," "tumor," "childbirth," "abortion," "miscarriage," "stillbirth," "fracture," "injuries," "burns," "drowning," "poisoning," "asphyxia," "suffocation," "strangulation," "homicide," "suicide," "accident," "found dead," "died suddenly," "died while at work," "died in bed," "died in hospital," "died on the way to hospital," "died at home," "died in jail," "died in police station," "died in fire," "died in automobile," "died in train," "died in boat," "died in airplane," "died in mine," "died in factory," "died in store," "died in office," "died in school," "died in church," "died in theater," "died in hotel," "died in restaurant," "died in saloon," "died in brothel," "died in prison," "died in asylum," "died in poorhouse," "died in workhouse," "died in reformatory," "died in penitentiary," "died in jail," "died in police station," "died in fire," "died in automobile," "died in train," "died in boat," "died in airplane," "died in mine," "died in factory," "died in store," "died in office," "died in school," "died in church," "died in theater," "died in hotel," "died in restaurant," "died in saloon," "died in brothel," "died in prison," "died in asylum," "died in poorhouse," "died in workhouse," "died in reformatory," "died in penitentiary," should not be used. Physicians: please write the correct age is especially important.

G 16655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16655 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 664 N. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 664 N. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Hemsley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25. 1916

8. AGE: Years	Months	Days	If less than one day
28	4	2	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Charles Anderson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Helen Reed
15. Birthplace Baltimore Maryland

16 (a) Informant Helen Anderson Mother
(b) Address 815 W Saratoga St apt 2

17 (a) Burial (b) Date thereof May 2. 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Olive
Location Baltimore County

18 (a) Funeral director Joseph A. Lively
(b) Address 4000 Mount st

19 (a) APR 28 1944 Hunting G. Wells Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 5:25 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection, Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardio - vascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed April 27, 1944.

VS 151

Correct age to be expressed in years. If a physician, please write this.

G 16656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G 16656 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/28/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 3/28/44

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Shepherd St., N.W.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIE ELWOOD SELLERS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nellie A. Cammariere
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 5/27/1885

8. AGE: Years 58 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Southport, N. C.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business U.S. Eng. Corps

FATHER
12. Name John Sellers
13. Birthplace Southport, N.C.

MOTHER
14. Maiden Name Sallie Fountain
15. Birthplace Darlington, S.C.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof 5 - 1 - 1944 (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln
Location Prince George county

18 (a) Funeral director Francis J. Collins
(b) Address 3821 - 14th St. N.W. Wash. D.C.

19 (a) Date filed by registrar APR 28 1944 (b) Registrar's signature Huntington Williams, MD

MEDICAL CERTIFICATION A.

20. DATE OF DEATH April 28, 1944 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 28, 1944 to Apr. 28, 1944 and that I last saw h[illegible] in alive on Apr. 28, 1944

Immediate cause of death 1. Carcinoma of the esophagus, post operative; 2. Congestion, edema, and early
Disease bronchial pneumonia of both lungs — Duration 4-5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/1-Gastroscopy; 4/25-Esophagoscopy with biopsy; 4/26-Esophagectomy; Partial Esophagectomy

Findings: As above Fl.

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Caldwell MD
Address Baltimore, Md. Date signed 4/28/44

USEC-51998

Report age is especially important. Physicians, please write plainly.

G 16657 ✓ X G 16657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. General
(c) Hospital or institution Hosp. Balt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. ~~W. R.~~ William R. Engleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 5-1-1944 (month) (day) (year)

(c) Cemetery or crematory Krider's

Location Westminster Md

18 (a) Funeral director E. Reese

(b) Address Westminster Md

19 (a) (b)

APR 28 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28/44 19 , at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1944, to 4/28 1944, and that I last saw him alive on 4/28 1944.

Immediate cause of death H. C. V. D. | Duration

Due to Prostatic hypertrophy

Due to Secondary Anemia

Other Conditions Uterine

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ( ) While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. H. Mayer M. D.

Address Md. General Hosp. Date signed 4/28/44

Please write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

6658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 16658
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Lang

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1944

8. AGE: Years | Months | Days | If less than one day: 12 hr. 40 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name David Lang
13. Birthplace Florida

MOTHER
14. Maiden Name Mattie Painter
15. Birthplace North Carolina

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 28 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

10905

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 2.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944, to April 19 1944, and that I last saw h.er alive on April 19 1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stefton, Jr. M. D.
Address Johns Hopkins Hospital Date signed 4-24-44

correct age is especially important. Physicians, please write

G 16659 — Waitkus ✓ — G 16659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registrar's No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S Potomac St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 /
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 5 S Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Waitkus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: Julia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1-1872

8. AGE: Years 70 | Months 8 | Days 27 26 | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name ? Waitkus
13. Birthplace Lithuania

MOTHER 14. Maiden Name Jonkus
15. Birthplace Lithuania

16 (a) Informant Julia Waitkus
(b) Address 5 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-44 (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John C Moran
(b) Address 2800 Baltimore St

(a) Local Registrar (b) Hunting for Williams, M.D. Registrar

APR 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944 to April 27 1944, and that I last saw h[illegible] alive on April 26 1944.

Immediate cause of death: Cardiac thrombosis / Arteriosclerosis — Duration

Due to: Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature A Kent Hurley M. D.
Address 2936 Gard Date signed 4-28-44

correct age is especially important. Physicians please write

G 16660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 16660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes name country

3 (a) FULL NAME John. T. Kertney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14-1899

8. AGE: Years 44 | Months 6 | Days 12 | If less than one day hr min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John T. Kertney
13. Birthplace Martinsburg Va.

MOTHER 14. Maiden Name Mary Callahan
15. Birthplace Balto. Md.

16 (a) Informant Mary Kertney
(b) Address 3909 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29-44 (day, year)
(c) Cemetery or crematory New Cathy.
Location Old Frederick Rd.

18 (a) Funeral director John. J. McGan
(b) Address 3700 E. Balto. St.

APR 28 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 26-44 19 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944 to 4/26 1944 and that I last saw h[illegible] alive on 4/25 1944.

Immediate cause of death Myocardial insufficiency — Duration 1 yrs.

Due to —

Due to —

Other Conditions None.

(Include pregnancy within 3 months of death).

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Greyton M.D.
Address 3963 Greenmount Ave. Date signed 4/27/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16661

McGuire

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 936

G 16661 ✓

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 E. 22nd St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Hanlon Negus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 75 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Baltimore Co
(Town, county, and state)

10. Usual Occupation Home Life

11. Industry or business

FATHER
12. Name Michael Hanlon
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Nagel
15. Birthplace Ireland

16 (a) Informant Mrs Edward L. Lynch
(b) Address 731 E. 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-1944 (month) (day) (year)
(c) Cemetery or crematory St Charles Cemetery
Location Pikesville

18 (a) Funeral director Mary M Warfield
(b) Address 501 E. 22nd St

19 (a) APR 28 1944 (Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26/1944, at 11:6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20/1943 to 4/26/1944, and that I last saw h. alive on 4/25/1944.

	Duration
Immediate cause of death Myocardial Insufficiency	4 days
Due to Myocarditis	1 Year
Due to	
Other Conditions Chr. Passive Congestion of Liver with Ascites	1 mo

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Thomas J White M. D.

Address 532 E. 22nd Date signed 4/28/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16662

BALTIMORE CITY HEALTH DEPARTMENT X V G 16662

CERTIFICATE OF DEATH 82

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Betterton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1937

8. AGE: Years	Months	Days	If less than one day
6	7	25	hr. min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James M. Sutton
13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Sutton
15. Birthplace Maryland

16 (a) Informant Hospital Record
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof May 7, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stull Pond
Location Stull Pond Md

18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, Md

19 (a) (b)
(Signature and address of registrar)

APR 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1944 at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1944 to 4/28 1944
and that I last saw him alive on 4/28 1944

Immediate cause of death Encephalitis
Bulbar Palsy

Duration
2 days
2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Shortle M.D.

Address University Hosp. Date signed 4/29/44

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

16663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G 16663

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 S. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. Child

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24/43.

8. AGE: Years	Months.	Days	If less than one day
1	1	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Howard A. Robinson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Helen McDermanski
15. Birthplace Baltimore

16 (a) Informant Howard Robinson
(b) Address 209 S Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Fred W. Ograzewski
(b) Address 1930 Eastern Ave
19 (c) (Date received by Registrar) Hunting to Williams Mfr (Registrar)

APR 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944 at 2 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1944 to 4-28 1944 and that I last saw him alive on 4-28 1944.

Immediate cause of death Tuberculous meningitis — Duration

Due to

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan

Address St Joseph's Hospital Date signed 4-28-44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

G 16664 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 W. 37½ st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 W. 37½ st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac N. Ambrose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Mary E. Ambrose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4th 1854

8. AGE: Years 89 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Black Rock, Balto. Co.
(Town, county and state)

10. Usual Occupation Retired

11. Industry or business Main Foreman

FATHER 12. Name Ambrose

13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Sarah Miller

15. Birthplace Balto. Co. Md

16 (a) Informant Mary E. Ambrose

(b) Address 1128 W. 37th st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/29/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St. Marys

Location Kampdeh

18 (a) Funeral director William Cook Sons

(b) Address 1217 St. Paul st

(Date received by registrar) APR 29 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1944, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1944, to April 25 1944, and that I last saw him alive on April 25 1944.

Immediate cause of death: Uremia — Duration 4 days

Due to: Enlarged Prostate — Duration 3 mo

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. V. Teagarden

Address 603 Club Road Date signed 4/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 16665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 Cambridge St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** James W. Nelson, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, (married), widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs J. W. Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1879

8. AGE: Years 64 | Months 11 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mr James W Nelson
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Catherine ?
15. Birthplace MARYLAND

16 (a) Informant Admission sheet
(b) Address

17 (a) Burial (b) Date thereof July 1. 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St Extended

18 (a) Funeral director Wickham Cook Inc
(b) Address 1217 Eutaw Place

19 (a) (b)

APR 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1944 at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944 to 4-27 1944 and that I last saw h.i.m alive on 4-27 1944.

Immediate cause of death: CARDIO-RESP. FAILURE — Duration: 7

Due to: ARTERIO-SCLEROTIC HEART DISEASE

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen J. Van Dell M. D.
Address Union Memorial Hosp. Date signed 4-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G 16666

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Underwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Regina Mc Ginn (McGinn)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) about 1890

8. AGE: Years	Months	Days	If less than one day
about 54			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business Rel. Householder

FATHER
12. Name Thomas Mc Ginn
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Hagan
15. Birthplace Md.

16 (a) Informant Joseph M. Smith
(b) Address 4004 Colbourne Rd

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1767 St. Paul st

19 (a) APR 29 1944 (b) Hunting for Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28-1944, at 1:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra-Cranial Hemorrhage

Due to

Other Conditions Multiple fractures, laceration abrasions contusions + bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-27- at 12/1 4 A M.
(b) Where did injury occur? Greenmount Ave - Underwood Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 4-28-44

16667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16667

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 N. Potomac Ste.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 603 N. Potomac Ste. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. Moffet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Wh.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha L. Moffet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/1892

8. AGE: Years 51 Months 7 Days 19 If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Moffet

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Nellie Brandau

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Bertha L. Moffet

(b) Address 603 N. Potomac Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 29-44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director John G. Connelly

(b) Address 416 Eastern Blvd.

19 (a) Filed (month) (day) (year) (b) Huntingtown Williams, M.D.

APR 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25 1944 at 7.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1944, to 4-25 1944, and that I last saw h. alive on 4-15-44

Immediate cause of death Pulmonary Tuberculosis — Duration 1y.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Moffett M. D.

Address 603 N. Potomac Ste Date signed 4-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered, or a delay will occur. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

16668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16668 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ascertained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Bryant Ave
(c) Hospital or institution:

13-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Blum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frieda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1885

8. AGE: Years 58 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Sidney Blum
13. Birthplace Russia

MOTHER
14. Maiden Name Bertha ?
15. Birthplace Russia

16 (a) Informant Dr Joseph Blum
(b) Address 2215 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Sharrei Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

APR 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1944, at 7.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11/ 1944 to 7/28 1944 and that I last saw h[illegible] alive on 4/27 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration: 24.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Jesse M.D.

Address 11 E. Chase St. Date signed 4/29/44

G 16669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 16669

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & John St

(c) Hospital or institution Hospital for Women of Md 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1023 Bolton St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Mary Jenkins Litsinger

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced ✓

6 (b) Name of husband or wife: ✓

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Trappe Md. (Town, county, and state)

10. Usual Occupation: Home duties

11. Industry or business

FATHER — 12. Name

13. Birthplace

MOTHER — 14. Maiden Name

15. Birthplace

16 (a) Informant: Mrs. Armstrong Kirby

(b) Address 149 N. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Fulton & Oak Ave.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

APR 29 1944 (Date received) (b) Huntington Williams Mgr (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944, at 8:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944, to April 28 1944, and that I last saw h[illegible] alive on April 26 1944.

	Duration
Immediate cause of death: Respiratory Failure	
Hypostasis	
Due to: Cerebral Embolism	
Auricular Fibrillation	
Due to: Hypertensive Cardio Vascular Disease	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Meuland Edward Day M. D.

Address Hosp for Women Md Date signed 4/28/44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16670

G 16670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 1314

1. PLACE OF DEATH Edgewood Nursing Home

CITY OF BALTIMORE: (No. 6000 Belloria Ave St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Annie J. Lyons

If U. S. Veteran specify WAR

(a) Residence: No. 6000 Belloria ave St., 27-12 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Feby 12, 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
90	2	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Cumberland Md.

FATHER

13. NAME John G. Lyons

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Rebecca Singleton

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs Rosalie Magruder

(Address) Cambridge Md

18. BURIAL, CREMATION, OR REMOVAL

Place Cumberland Md. Date Apr 29 1944

19. UNDERTAKER John A. Mitchell & Sons

(Address) 634 E Eutaw Place

20. FILED APR 29 1944 19 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 27. 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct. 16 19 41 to June 27 19 44

I last saw her alive on April 27 19 44 Death is said to have occurred on the date stated above, at 8.40P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	Indef
Other contributory causes of importance:	
Arteriosclerosis & Chronic Nephritis	indef

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. A. Chenoweth M. D.

(Address) 1120 W. 25th St

Public CAUSES OF DEATH in plain terms. See instructions on back of certificate.

OCCUPATION is very important.

16671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16671
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W University Pkwy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan T Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 11 1862

8. AGE: Years 81 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name William Brown
13. Birthplace New York

MOTHER
14. Maiden Name Ann McCulloh
15. Birthplace Maryland

16 (a) Informant Duncan McCulloh
(b) Address Glencoe Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29/44 (month) (day) (year)
(c) Cemetery or crematory Emmanuel
Location Glencoe Md

18 (a) Funeral director Henry W Jenkins Sons
(b) Address McCulloh & Orchard Hunting Towson, Md

19 APR 29 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1926 to 4/27 1944
and that I last saw h[illegible] alive on 4/27 1944

Immediate cause of death Coronary Thrombosis — Duration 2 yrs

Due to Myocarditis Arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Brady M. D.
Address 1403 Park Ave Date signed 4/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G 16672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G 16672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Dolphin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Hendricks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1881

8. AGE: Years 63 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ? Wood
13. Birthplace

MOTHER
14. Maiden Name Hollis ?
15. Birthplace

16 (a) Informant Mrs. Edw. Nash
(b) Address 746 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hessley
(b) Address 507 & W Biddle St

APR 29 1944 (Date rec'd by registrar) (c) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of breast with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraley M.D. Medical Examiner.
Date signed April 27, 1944

452123

16673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

G 16673
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 E. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-22

8. AGE: Years 21 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name George Dixon
13. Birthplace Md

MOTHER: 14. Maiden Name Myrtle King
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL 4/29/44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director William M Marech
(b) Address 3[illegible] Light St

APR 29 1944

19 (a) (Date rec'd by registrar) (b) [illegible] Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944 to April 26 1944 and that I last saw deceased alive on April 26 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Rheumatic heart disease, mitral stenosis & M.R., M.S. A.I.,	13 yrs
Due to and tricuspid Insufficiency cardiac enlargement	
Other Conditions cardiac failure	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Omansky M.D.
Address J. Hopkins Date signed 4-27-44

G 16674

16674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 N. Longwood Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N. Longwood Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WILSON KING GREER

3 (b) If veteran, name war	3 (c) Social Security Account No.
World	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1887

8. AGE: Years	Months	Days	If less than one day
56	9	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business Bethlehem Steel

FATHER
12. Name William S. Greer
13. Birthplace

MOTHER
14. Maiden Name Laura A.
15. Birthplace

16 (a) Informant Mrs. Frances Greer
(b) Address 719 N. Longwood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

19 APR 29 1944 (Date rec'd by Registrar) (b) Hunting for Williams, M.D.

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 7:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1943, to April 26, 1944, and that I last saw him alive on April 26, 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration
Due to
Due to
Other Conditions: Operated on for Strangulated hernia.
(Include pregnancy within 3 months of death)
Date of operation January 23, 1944
Major findings of operation: Strangulated hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Kemp M. D.
Address 3030 Edmondson Ave. Date signed 4/27/44

16675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16675
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 S. Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 S Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1872

8. AGE: Years 71 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Cambridge Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jarvis Griffin
13. Birthplace Md

MOTHER
14. Maiden Name Castle Carr
15. Birthplace Md

16 (a) Informant Isabella Jones (C)
(b) Address 529 S Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co., Md

18 (a) Funeral director Joseph L. Brown & Son
(b) Address 108 W Montgomery St

APR 29 1944 (Local registrar) (b) Huntington, W. Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 24 1944 at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1944 to 4/24 1944, and that I last saw h[illegible] alive on 4/24 1944.

Immediate cause of death: Chronic Cardio vascular Renal disease — Duration: 1 year
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. W. Jackson M. D.
Address 600 Washington Date signed 4/27/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16676

16676
AB-87463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 136

G 16676
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

4-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Diamond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Wynn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Gladys
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1906

8. AGE: Years 37 | Months 3 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wynn
13. Birthplace N.C.

MOTHER
14. Maiden Name Lula Tarr
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 29.44 (month) (day) (year)
(c) Cemetery or crematory
Location Benson. N. C.

18 (a) Funeral director Isaac L Brown Son
(b) Address 1056 Montgomery Street

APR 29 1944 (Date received by Registrar) (b) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944 to 4/27 1944
and that I last saw h alive on 4/27 1944

Immediate cause of death TBC — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pul. TBC Emphysema Pleural Adhesions. Tuberculous Ulceration Trachea

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. L. Seegmiller M.D.
Address BCH Date signed 4/28

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16677

Z - 87603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G 16677 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hrs.-6min
(e) Length of stay in Baltimore (yrs., mos., or days) 15 hrs. 6mins

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842½ W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brinsfield, Baby Boy(Pauline)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1944

8. AGE: Years | Months | Days | If less than one day: 15 hr. 6 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Earl Brinsfield
13. Birthplace ?

MOTHER
14. Maiden Name Pauline Marshall
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29/44 (mo.) (day) (yr.)
(c) Cemetery or crematory Cambridge Cem.
Location Cambridge, Md.

18 (a) Funeral director Le Compte Funeral Service
(b) Address Cambridge, Md.

APR 29 1944 (Date rec'd by registrar) Emelia to Williams, M.F. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Cross out words not necessary to complete or correct statement. Underline or fill in correct answer. Be sure to answer every question. Where information is unknown or inapplicable, write "unknown" or "none." Do not write in spaces marked "Registrar." Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 1944 at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1944 to 4-24 1944 and that I last saw him alive on 4-24 1944

Immediate cause of death: Congenital Atelectasis and Intracranial hemorrhage — Duration

Due to: Prematurity

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balto. City Hosp. Date signed 4-24-44

VS 150

16678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-7E

G 16678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifetime
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1315~~ 3915 Hollins Ferry Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Chester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1888

8. AGE: Years 55 50 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Balt Baltimore, Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Charles Chester
13. Birthplace Md

MOTHER
14. Maiden Name Clara Belt
15. Birthplace Frederick Md

16 (a) Informant Clara Chester
(b) Address 3915 Hollins Ferry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Peter R Williams
(b) Address 3234 Schroeder St

19 (a) APR 29 1944 (Date rec'd by registrar) per Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944, at 11 05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Die death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypophyseal Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Feather M.D. Medical Examiner.
Date signed April 26, 1944

VS 151

16579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 119a

Registered No. G 16679

Please write the causes of death clearly and legibly. Physicians: please write plainly. Do not use abbreviations.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 2 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 1/2 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29, 1944

8. AGE: Years	Months	Days	If less than one day
		29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John L. Williams Jr.
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Dorothy Carter
15. Birthplace Greensboro, N C.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof April 29, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 522 N Schroeder St

APR 29 1944 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1944, at 5:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1944 to 4/27 1944, and that I last saw h.r alive on 4/26 1944.

	Duration
Immediate cause of death Peritonitis	24hrs
Due to Enteritis	14 days
Due to Prematurity	
Other Conditions Dehydration	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Perforation of Ileum
Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Shortle M. D.
Address University Hosp. Redwood & Greene Date signed 4/27/44

G 16680

JO #87469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 16680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Douglass

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lena Douglass
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1878

8. AGE: Years 66 | Months -1- | Days -0- | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Charles Douglass (d)
13. Birthplace Conn.

MOTHER
14. Maiden Name Eliza Gaskins (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 APR 29 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944 to 4-26 1944 and that I last saw h alive on 4-26 1944.

Immediate cause of death — Duration

Probable Coronary Thrombosis
Due to Arteriosclerotic Cardio-vascular Disease
Due to Urinary Extravasation
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-15-44
Major findings of operations: Urinary Extravasation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Kelly M. D.
Address Balt City Hosp Date signed 4-26-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly

G 16681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓186a

Registered No. G 16681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Lamont Avenue
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Lamont Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Stafford

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Hall
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 17th, 1882

8. AGE: Years 62 | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired Stationary Engineer
11. Industry or business

FATHER
12. Name Andrew Stafford
13. Birthplace Ireland

MOTHER
14. Maiden Name (Unknown)
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine Mackin (Daughter)
(b) Address 1731 Lamont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b) Huntington Williams, M.D.

APR 29 1944
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28th 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to April 28 1944, and that I last saw him alive on April 28 1944

Immediate cause of death: Cerebral Hemorrhage
Duration 5 hrs
Due to: Hypertensive Arterio-Sclerotic C-V disease
Duration 5 years
Due to:
Other Conditions: Fracture left humerus
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 3, 1944 | M
(c) Where did injury occur? 1731 Lamont Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Air Base (Specify type of place) While at work? no
(e) Means of injury Fell striking on ground

23. Signature W. H. Brenizer M.D.
Address 402 E. Lanvale St. Date signed 4-28-44

For A. J. Lubinski, by Howard J. Mullen, M.D.

Notice: Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

G 16682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 16682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 E. 25th St.
(c) Hospital or institution:

8-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 25th St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA JANE VOGEL

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife Wesley V. Vogel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1868

8. AGE: Years 75 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Harford County, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Thomas Biddison
13. Birthplace Unknown

MOTHER
14. Maiden Name Eliza G. German
15. Birthplace Unknown

16 (a) Informant Mrs. Carrie B. Trexler
(b) Address 1603 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore County, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 29 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 27 1944, at 12.40

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/44 19 , to 4/27-1944.
and that I last saw h alive on 4/25/44

Immediate cause of death Carcinoma Breast — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. H. Trexler M. D.
Address 1710 E 33rd St. Date signed 4/28/44

Hunting for Williams M.

G 16583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 16583 Registered No.

Correct age is supremely important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N Caroline St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Chas Ringgold

3 (b) If veteran, name war

3 (c) Social Security Account No. 206-01-9802

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Bertha Ringgold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16 unknown

8. AGE: Years	Months	Days	If less than one day
approx 60			hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Waiter
11. Industry or business Cafe

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Annie Atwood
15. Birthplace unknown

16 (a) Informant Bertha Ringgold
(b) Address 907 N Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Ambrose Cem
Location Baltimore Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1900 Jefferson St

APR 29 1944
(Date rec'd by registrar)

19 (a) (b) Huntingtown Williamsport Md

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1944, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to April 25 1944, and that I last saw him alive on April 24 1944.

Immediate cause of death	Duration
Central Intestinal Obstruction	Jan 1944
Due to Carcinomatosis Recently in Ascending Colon	6 mos
Due to	
Other Conditions Mitral Regurgitation	unknown

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J Harris
Address 1424 E Monument St Date signed 4/26/44

G 16684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16684 Registered No.

Please write plainly with ink or indelible pencil. Do not use abbreviations. If the cause of death may be the result of an accident, violence, or poisoning, fill in also the questions on the reverse side. Make a full and complete return to every question. If unknown, say so.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Thames St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jesse Rodriguez

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 - 1941

8. AGE: Years	Months	Days	If less than one day
3	0	26	hr. min.

9. Birthplace Baltimore md. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

MOTHER / FATHER

12. Name Jesse Rodriguez

13. Birthplace Spain

14. Maiden Name Blanca Garcia

15. Birthplace Venezuela. S.A.

16 (a) Informant Record.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 1/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geeler INC.

(b) Address 407 S. WOLFE ST.

19 (a) APR 29 1944 (b) Hunting for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to April 27 1944, and that I last saw him alive on April 27 1944.

Immediate cause of death Shock

Due to Meningococcus meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

22. Signature Leonard Joel Koenig M. D.

Address J. H. H. Date signed 4-28-44

G 16685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No. G-16685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
(c) City or town ROSEDALE Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7931 Shirley Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Norval D. Zaicka

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-20-8748

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Aug 17 1924

8. AGE: Years 19 | Months 8 | Days 17 | If less than one day: hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Machinest

11. Industry or business U. L. Martin

FATHER
12. Name Ignatius Zaicka
13. Birthplace Russia

MOTHER
14. Maiden Name Mary A. Zeitzer
15. Birthplace Baltimore, Md.

16 (a) Informant Mary A. Zeitzer Zaicka
(b) Address 7931 Shirley Ave.

17 (a) BURIAL (b) Date thereof May 3/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeibe INC.
(b) Address 403 S. WOLFE ST.

19 (a)..... (b) Hunter-Lee-Williams
(Date rec'd by registrar) Registrar

VS 1 APR 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of right femur, left tibia & fibula

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

If the final cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/23/44 at 1:40 P.M.

(b) Where did injury occur? Amelia & Eastern Ave

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? NO

(d) Means of injury Pedestrian struck by auto

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 4-27-44

G 16686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 16686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 EASTERN AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 30 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 EASTERN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE MOHR

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife PETER MOHR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant CECIL COWAN (SON IN LAW)
(b) Address 1940 WALBROOK AVE.

17 (a) BURIAL (b) Date thereof MAY
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.
18 (a) Funeral director Tilly and Zuler INC.
(b) Address 403 S. WOLFE ST.
19 (a) APR 29 1944 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH APR. 28 1944 at 7/30M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1943 to Apr. 28 1944, and that I last saw h[illegible] alive on April 27 1944.

Immediate cause of death	Duration
Cerebral apoplexy.	3 days.
Due to chr. Hypertension	several yrs
Due to chr. nephritis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature John J. Finger M. D.
Address Date signed 4/29/44.

Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

G 16687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3.00

Registered No. G 16687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4648 Rokeby Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella J. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edward B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb - 22 - 1873

8. AGE: Years	Months	Days	If less than one day
71	2	5	hr. min.

9. Birthplace Grafton, W. Va. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George H. Robinette
13. Birthplace W. Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr Bernard Smith
(b) Address 2810 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May - 1 - 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date received by registrar) (Registrar)

APR 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to April 28 1944, and that I last saw h alive on 19

Immediate cause of death Cerebral Thrombosis arteriosclerosis — Duration 1 year

Due to

Due to old age.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, or type of place)
(e) Means of injury

23. Signature Edgar H. Mortimer Md M. D.
Address 2761 St Paul St Date signed 4/28/44

G 16688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16688 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2227 McHenry Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 McHenry St. (If rural, give location)
(e) Citizen of foreign country Yes (Yes or No)
If yes, name country Hungary

3 (a) FULL NAME Michael Ostovitz

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-01-0474

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth B. Ostovitz

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 5, 1882

8. AGE: Years 61 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Hungary (Town, county and state)

10. Usual Occupation Butcher

11. Industry or business Albert Goetz Co.

FATHER
12. Name Charles Ostovitz
13. Birthplace Hungary

MOTHER
14. Maiden Name Anna ?
15. Birthplace Hungary

16 (a) Informant Elizabeth Ostovitz
(b) Address 2267 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George H. Schwab
(b) Address 2101 Frederick Ave

19 (a) (b) (Date received by registrar) Registrar

APR 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943, to 4-27 1944, and that I last saw him alive on 4-27 1944

Immediate cause of death: Coronary occlusion with myocardial infarction — Duration sudden death

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Morris B. Schreiber M. D.
Address 54 S. Fulton Ave Date signed 4-28-44

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly. The number of Social Security supplied. The

G 16689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 16689 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) four years

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Delta (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Dougherty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1863

8. AGE: Years 80 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name Michael Dougherty
13. Birthplace Ireland

MOTHER: 14. Maiden Name Mary McGraw
15. Birthplace Ireland

16 (a) Informant Miss Mont Dougherty
(b) Address 900 14th St. N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 1944 (month) (day) (year)
(c) Cemetery or crematory St. Mary
Location Baltimore Md.

18 (a) Funeral director J. Thomas Hyde
(b) Address Towson, Md.

19 APR 30 1944 (Date rec'd by registrar) (b) Thurston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1944, at 2:26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1944 to 4-30 1944, and that I last saw h[illegible] alive on 4-29 1944

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cerebro-vascular accident	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Ozazlucka M. D.
Address Mercy Hosp. Date signed 4-30-44

G 16690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 16690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6dys
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 w. Mt. Royal ave 17 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME John Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Shipyard worker
11. Industry or business Maryland Dry Docks Co.

FATHER
12. Name ? Thomas
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. R.L. Carter Charlottesville
(b) Address 619 alta vista ave va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Charlottesville Va.
Location.....

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) ..... (b) ..... (Registrar)
APR 30 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29/44 19.. at 9:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944 to 4/29 1944, and that I last saw him alive on 4/29 19 44

Immediate cause of death	Duration
Respiratory failure	
Due to Tuberculosis & pneumonia	
Due to.....	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operations:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.....

23. Signature Chas Ralph Jr. M.D. M. D.
Address Univ Hosp Date signed 4/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16691 BALTIMORE CITY HEALTH DEPARTMENT G 16691
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 12 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Battolity.
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Clarence Dell

3 (b) If veteran, name war None — | 3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1880 May 26 1881

8. AGE: Years 63 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business

FATHER 12. Name Edgar F. Dall
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Sally Scott
15. Birthplace New Jersey

16 (a) Informant Mrs Marian D. Wallace (sister)
(b) Address 3015 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30/44 (month) (day) (year)
(c) Cemetery or crematory Green Cemetery
Location Woodbury N. J.

18 (a) Funeral director Stewart Memorial Co.
(b) Address 108 W Mt Royal Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

APR 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1944, at 4 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1944 to 4-28 1944, and that I last saw him alive on 4-28 1944

	Duration
Immediate cause of death: Cardio-respiratory failure	
Due to: Hypertensive C-V. Disease Arteriosclerosis	
Due to: Bilateral Bronchopneumonia	
Other Conditions: Congenital infantile ut. Kidney - ureter	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: (See above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Dell Jr. M. D.
Address Union Memorial Hosp Date signed 4-29-44

4529316692 ✓ G 16692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4223 White Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William Foote

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-2677

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Pearl Foote
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 12-6-88

8. AGE: Years	Months	Days	If less than one day
55	4	22	hr. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation Photographer
11. Industry or business Balto. Sun Paper

FATHER
12. Name Zacharias Foote.
13. Birthplace md.

MOTHER
14. Maiden Name Anna Burkehart.
15. Birthplace md

16 (a) Informant Reverde.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1st 1944 (month) (day) (year)
(c) Cemetery or crematory Pashwood
Location Baltimore, Maryland

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) APR 30 1944 (Registrar) (b) Entered by Williams MR

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944, at 5.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944, to April 28 1944, and that I last saw him alive on April 28 1944.

Immediate cause of death	Duration
Uremia	
Due to Malignant arteriolar Nephrosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Cornbrooks
Address J. Hopkins Date signed 4-29

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 16693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 16693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Homestead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. MERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles Edward Merson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1865

8. AGE: Years	Months	Days	If less than one day
79	0	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Unknown Roemer
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Catherine Bush
(b) Address 1313 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Balto., Md.

19 (d) APR 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 28, 1944 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24, 1944 to April 28, 1944. and that I last saw her alive on April 28, 1944

Immediate cause of death: Carcinoma of the Colon — Duration: 4 months
Due to:
Due to:
Other Condition: Chronic Myocarditis — 1 year
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert Date signed Apr. 29.

Correct age is especially important. Physicians please write the causes of death clearly and legibly.

G 16694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16694 Registered No. 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 S. Hanover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET SHANE

3 (b) If veteran, name war: No
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife North M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1865

8. AGE: Years 78 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Golden Ring, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Paul Gegner
13. Birthplace Germany

MOTHER: 14. Maiden Name Catherine Michling
15. Birthplace Germany

16 (a) Informant Mr. Edward M. Shane
(b) Address 409 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 30 1944 (Date received) (b) Hunting Tom Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1944, at 5:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to April 28 1944 and that I last saw h[illegible] alive on April 27 1944.

Immediate cause of death Carcinoma of Breast — Duration ?

Due to

Due to

Other Conditions Liver Metastases
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Klassman M.D.
Address 753 W Fayette St Date signed 4/29/44

Correct age is especially important. Physicians: please write plainly. Give the cause of death clearly and legibly.

G 16695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16695
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 N. Payson St.
(c) Hospital or institution:

16 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA ALICE HARVEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry Calvin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1877

8. AGE: Years	Months	Days	If less than one day
66	6	10	hr. min.

9. Birthplace Pugwash, Nova Scotia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Mark Bergman
13. Birthplace Pugwash, Nova Scotia
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. H. C. Harvey
(b) Address 718 N. Payson St.

17 (a) Burial (b) Date thereof 5/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
APR 30 1944
19 (a) (b)
(Date rec'd by registrar) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1944, at 2:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24/44 to 4/28/44, and that I last saw her alive on 4/28/44

Immediate cause of death Respiratory failure — Duration
Due to Tuberculosis lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isadore Slonofsky MD
Address 601 N. Monroe St. Date signed 4/29/44

correct age is especially important. Physicians: please write plainly.

VS 150

G 16696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 W. 27th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 W. 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH DITTY HOPKINS or (ELIZABETH DITTY)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Hopkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1865

8. AGE: Years 79 | Months 2 | Days 15 | If less than one day: hr. min.

9. Birthplace: Prince George Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joshua T. Clark
13. Birthplace: Prince George Co., Md.

MOTHER
14. Maiden Name: Christina Hopkins
15. Birthplace: Prince George Co., Md.

16 (a) Informant: Mrs. Irene Cox
(b) Address: 321 W. 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's Cem.
Location: Laurel, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

APR 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1944 at 4:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4, 1944 to April 28 1944 and that I last saw h[illegible] alive on April 26 1944

Immediate cause of death: Cerebral Apoplexy — Duration 2½ mos.
Due to: Arteriosclerosis Cardio-Vascular Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. Weiss M. D.
Address: 1927 E. North Ave. Date signed: 4/29/44

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16697 ✓ G 16697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 698 Gladstone Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 698 Gladstone Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMILIE W. PROBST

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Luther K. Probst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1856

8. AGE: Years	Months	Days	If less than one day
87	9	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Wood
13. Birthplace Pa.

MOTHER
14. Maiden Name Christiana Lukens
15. Birthplace Pa.

16 (a) Informant Miss Carrie Mae Probst
(b) Address 698 Gladstone Ave.

17 (a) Burial (b) Date thereof 5/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 30 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1944, at 4:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944, to April 28 1944, and that I last saw h.r alive on April 28 1944

Immediate cause of death	Duration
Intestinal Obstruction	1 day.
Due to Cardiac decompensation	1 day
Due to Senile atrophic changes	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert F. Richman M. D.
Address 6 E Biddle St Date signed 4/29/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 16698 ✓ G 16698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 865 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 865 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUISA BRENGLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1859

8. AGE: Years	Months	Days	If less than one day
84	7	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Langeluttig
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Muhl
15. Birthplace Germany

16 (a) Informant Mr. H. Langeluttig
(b) Address 429 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 30 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944 to April 27 1944, and that I last saw h[illegible] alive on 4/27 1944.

Immediate cause of death Arteriosclerotic cardio vascular disease — Duration 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 2030 Wilkens ave. Date signed 4/29/44

correct age is especially important. Physicians, please write clearly and legibly.

G 16699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16699 Registered No. 8012

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves.
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEASCED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Liberty Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Master William Howes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21 1943

8. AGE: Years | Months: 8 | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William G. Hawes Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Zittle
15. Birthplace Maryland

16 (a) Informant Mr. Wm. G. Hawes
(b) Address 4015 Liberty Hgts. Ave

17 (a) Burial (b) Date thereof 5/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Washington Blvd.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

APR 30 1944 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29/44 19 , to 4/29/44 , and that I last saw h[illegible] alive on 4/29/44

Immediate cause of death: Encephalitis (non-epidemic) — Duration

Due to Etiology unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Congested Viscera

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M.D.
Address St Agnes Hosp Date signed 4/29/44

G 16700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16700 Registered No. 83a

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT LOUIS MYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1857

8. AGE: Years	Months	Days	If less than one day
87	3	11	hr. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)
10. Usual Occupation Retired Freight Agent
11. Industry or business B. & O. R. R.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Mary Anna Myer
(b) Address 2702 W. North Ave.

17 (a) BURIAL (b) Date thereof 5/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Grove Cem.
Location Cincinnati, O.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Signature)

APR 30 1944 Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH April 29, 1944, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 44, to April 29 44 and that I last saw him alive on April 28 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Mullen M.D.
Address 2757 W. Mnt Date signed 4/29/44

G 16701 G 16701

YA

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 56E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Belto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Matthew St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Naughton

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: James Naughton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1892

8. AGE: Years	Months	Days	If less than one day
52	3	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Doxon
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer MD
Location Gallagher & Co Inc

18 (a) Funeral director Wilson Gordon Inc
(b) Address 17 E Fort Ave

APR 30 1944

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29/1944, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1944 to 4/29 1944 and that I last saw h[illegible] alive on 4/29 1944.

Immediate cause of death	Duration
C.P.C. of Lungs; con pulmonale	
Due to Bronchial asthma; H.C.V.D. & decomp.	
Due to	
Other Conditions Fibrosis of thyroid; adenoma of adrenal (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Seymour
Address 13 CH Date signed M 4 D. 29

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16702 Registered No. 1314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Merchant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara J. Foster

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	W

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Charles B. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1883

8. AGE: Years	Months	Days	If less than one day
60	5	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name James D. Daniel
13. Birthplace Md
MOTHER 14. Maiden Name Mary E. Wilson
15. Birthplace Md.

16 (a) Informant Next of kin Record
(b) Address

17 Burial (b) Date thereof 5/4/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E. Pratt St

19 (a) (b) Registrar
(Date received by registrar) Huntington Williams, M.D.

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 28 1944 at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944 to 4-28 1944 and that I last saw h[illegible] alive on 4-24 1944.

Immediate cause of death	Duration
Heart failure	
Due to Hypertension	
Due to Chronic Interstitial Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Stanley M. D.
Address University Hosp. Date signed 4/28/44

Correct age is especially important. Physicians, please write plainly.

G 16703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 16703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 N. Calvert St.
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3518 Belvedere Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Thomas Keough

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 15, 1874

8. AGE: Years 69 | Months 11 | Days 13 | If less than one day — hr. — min.

9. Birthplace Baltimore County, Md (Town, county, and state)

10. Usual Occupation attendant

11. Industry or business Spring Grove

FATHER
12. Name Patrick Keough
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Mannonie
15. Birthplace Ireland

16 (a) Informant Mr. P. K. Galvin
(b) Address 113 St. Mary's Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Texas Md.
Location " "

18 (a) Funeral director William Cox Inc
(b) Address 1217 St Paul St

19 (a) APR 30 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 28 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 25 1944, to Apr 28 1944, and that I last saw h[illegible] alive on Apr 28 1944.

Immediate cause of death	Duration
Cardiac Failure	2 hr.
Due to Coronary Arteriosclerosis	6 mo
Due to Cerebral Lesion	2
Other Conditions Hearty. Bronchitis	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. B. McCaddon M. D.
Address Mercy Hosp. Date signed 4/29/44

Please write the causes of death clearly and legibly. Physicians: please correct ages is especially important.

G 16704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G 16704 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5609 Rennert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES DANIEL HARDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/1892

8. AGE: Years	Months	Days	If less than one day
41	5	6	hr. min.

9. Birthplace Cumberland, Maryland (Town, county and state)
10. Usual Occupation Office Work
11. Industry or business General Motors

FATHER
12. Name Samuel Harden
13. Birthplace Garrett Co., Maryland

MOTHER
14. Maiden Name ? Miller
15. Birthplace Bedford Co., Maryland

16 (a) Informant Edward S. Harden
(b) Address 517 Reid Ave, Cumberland

17 (a) Removal (b) Date thereof April 30-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cumberland
Location Cumberland, Maryland

18 (a) Funeral director Cook & Co.,
(b) Address 217 S. Baltimore St.

19 (a) APR 30 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944 at 2 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed 4-30-44

VS 151

G 16705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

G 16705 Registered No.

PRESS WHILE PLANEL, WITH CARBON INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 N. Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 705 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kalal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or busin

FATHER
12. Name John Kalal
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria

16 (a) Informant E. Rather
(b) Address 705 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Elkridge Md.

18 (a) Funeral director Frank Brockton
(b) Address 900 W. Lexington St. Baltimore, Md.

APR 30 1944 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage
Apoplexy

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham for Howard J. Madden M.D.
Medical Examiner.
Date signed 4-28-44

G 16706

452810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16706

Registered No. 1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Duchek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-28

8. AGE: Years 23 | Months 2 | Days 22 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation tailoring

11. Industry or business

FATHER
12. Name Joseph Duchek
13. Birthplace Czech.

MOTHER
14. Maiden Name Mary Masek
15. Birthplace Czech.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Joseph Brockton
(b) Address 900 N. Chester St.
(c) Date received by registrar APR 30 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1944 to April 28 1944 and that I last saw her alive on April 28 1944

Immediate cause of death	Duration
Respiratory obstruction with edema & pharynx	
Due to uremia	
Due to Chronic glomerulo-nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Gerstein M.D.
Address J. Hopkins Date signed

AB-87513 G 16707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 16707 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 E. Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3-(a) FULL NAME Mary Spohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Feb. 13- 1863

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1863

8. AGE: Years 81 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Spohn
13. Birthplace Switzerland

MOTHER
14. Maiden Name Antonetta Smith
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-44 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Frederick Rd. Balto Md

18 (a) Funeral director Jos. P. Miller Inc
(b) Address 2435 E. Oliver St

APR 30 1944

(Registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 27 1944, at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1944, to 4-27 1944, and that I last saw her alive on 4-27 1944.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to Fracture R Hip	25 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental Fall
(b) Date of occurrence ? Apr 2 1944 at M
(c) Where did injury occur? Balto City Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Accidental Fall

23. Signature Donald H Hebb M. D.
Address Balto City Hosp Date signed 4-27-44

VS 150

Huntington Williams M.D. Registrar

APPROVED BY MEDICAL EXAMINER Howard J. Edwards, M.D.

G 16708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 E. Gittings St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 62

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 E. Gittings St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia L. Abbott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife Samuel Abbott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2. 1881

8. AGE: Years	Months	Days	If less than one day
62	10	27	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name August Niemann
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Beebo
15. Birthplace Baltimore Md

16 (a) Informant Etta Snyder
(b) Address 116 Willard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director Durward L. Covington
(b) Address 21 W. 25th St.

19 (a) (Signature of registrar) (b) Huntington Williams Registrar

APR 30 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1943 to 4-29 1944
and that I last saw h-r alive on 4-29 1944

Immediate cause of death: Chronic Myocardial Degeneration

	Duration
Due to Arteriosclerosis	8 mo.
Due to Diabetes Mellitus	1 yr.
Other Conditions	1 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ballod M. D.
Address 707 E. Fort Ave. Date signed 4-29-44

G 16709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

G 16709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma K Soine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife G William Soine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1864

8. AGE: Years	Months	Days	If less than one day
90	3	19	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name C G W Sigalen
13. Birthplace Germany

MOTHER
14. Maiden Name Marie D Lipps
15. Birthplace Germany

16 (a) Informant Mrs Marie Schultz
(b) Address 1815 N Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944, at 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1944, to April 28 1944, and that I last saw her alive on April 27 1944.

Immediate cause of death	Duration
Infirmities of age	
Due to Infirmities of age	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Perry Carman M.D.
Address 1701 N. Caroline St Date signed April 28 1944

G 16710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1312

G 16710

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Gutman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Gutman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M Lawrence

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months 60 | Days | If less than one day hr. min.

9. Birthplace Penna. Harford Co.
(Town, county, and state)

10. Usual Occupation
11. Industry or business — Waiter —

FATHER
12. Name
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Helen Young
(b) Address 607 Gutman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Mary M Woodford
(b) Address 301 E. 32nd St

APR 30 1944
(Date filed by Registrar) Cuthbert Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 28 19XX at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 19XX, to Apr 28 19XX, and that I last saw him alive on Apr 28 19XX

Immediate cause of death	Duration
Due to Chronic Nephritis	
Due to	
Other Conditions Valvular Heart disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Frahn M. D.
Address 1822 N. Mad 2e. Date signed 4/29/XX

G 16711 Page 1 Lib. 1 Mount St. BALTIMORE CITY HEALTH DEPARTMENT G 16711 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 W. Lexington St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Henderson Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Jane Johnson
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1891

8. AGE: Years	Months	Days	If less than one day
53	1	7	hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

MOTHER / FATHER
12. Name Moses Johnson
13. Birthplace Md
14. Maiden Name Lucinda Wilson
15. Birthplace Md

16 (a) Informant Jane Johnson
(b) Address 1629 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1100 Brantley Ave

19 APR 30 1944 (b) Registrar

VS 180 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 1944 at 8:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1944 to 4-24 1944 and that I last saw h. alive on 4-24-1944

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	1 Mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1616 N. Mount St. (17) Date signed 4-29-44

G 16712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16712 / 309

Registered No. G 16712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Gross

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Rachel Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1884

8. AGE: Years 59 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Coal + Wood Dealer

11. Industry or business

FATHER
12. Name William H. Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Katie ?
15. Birthplace Md.

16 (a) Informant Walter Gross
(b) Address 1118 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) 1000 Brentwood Ave

19 (a) APR 30 1944 (Date rec'd by registrar) (b) Hunting Ton Wellington, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured aneurysm of Aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D. Medical Examiner.
Date signed April 24, 1944

VS 151

G 16713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

G 16713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Floyd Hill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1939

8. AGE: Years	Months	Days	If less than one day
4	5	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation School-child

11. Industry or business

FATHER 12. Name Charles Hill

13. Birthplace Md

MOTHER 14. Maiden Name Pearl Ford

15. Birthplace Md.

16 (a) Informant Pearl

(b) Address 801 Rutland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brant Ave

19 (a) [illegible] (Date received by Registrar) (Signature of Registrar) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April X 1944 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/26/44 at 7/5 x 2 Xmd M.

(b) Where did injury occur? Monument + Wolfe Sts

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Pinned under street car

23. Signature H. L. Wollenmann M.D. Medical Examiner.

Date signed April 26, 1944

VS 151

G 16714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16714

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 453 Watty Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 453 Watty Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Pamplico, S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Tanner McWhite
13. Birthplace S.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Camelia Washington
(b) Address 453 Watty Court

17 (a) Burial (b) Date thereof 5-1-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Pamplico, S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) MAY 1944 (b) Wilson M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 1.30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Prin death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 29 1944

VS 151

G 16715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Shriner Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Nicholas Wissman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Torrisa Wissman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1861

8. AGE: Years 82 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Nicholas Wissman
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Hannah Deall
15. Birthplace Germany

16 (a) Informant Mrs. Madeline Scheurich
(b) Address 2115 Lake Montebello Terrace Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Signature of local registrar) (b) APR 30 1944 Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28th 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1944, to Apr 28 1944, and that I last saw him alive on Apr 27 1944

	Duration
Immediate cause of death: Bronchopneumonia	2 d.
Due to: Uremia coma	3 d.
Due to: Arteriosclerosis	2 mo
Due to: Hypertension	2 mo
Due to: Chronic interstitial nephritis	2 mo
Due to: Acute myocarditis	2 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E E Stevens M. D.
Address 2878 Harford Rd Date signed Apr 29 1944

G 16716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 462

G 16716

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1610 Patapsco St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Frederick

(c) City or town Myersville Rural
(If outside city or town limits, write Rural, and give town)

(d) Street No. Pleasant Walk
Myersville (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Wesley Poore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Clara Saylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 / 23 / 1861

8. AGE: Years 73 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Myersville Frederick Co. Md
(Town, county, and state)

10. Usual Occupation Retired Stone Mason

11. Industry or business

MOTHER / FATHER

12. Name Josiah Poore

13. Birthplace Md

14. Maiden Name Rebecca Mantooth

15. Birthplace Md

16 (a) Informant Wilbur Poore

(b) Address Myersville Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5 / 2 / 44 (month) (day) (year)

(c) Cemetery or crematory U. B. Cemetery

Location Frederick Co. Md

18 (a) Funeral director J. Thos. Bittle Sons

(b) Address Myersville Md

APR 30 1944 (Date of Registration) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1944 at 6:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20, 1944 to April 29 1944 and that I last saw h alive on 4/28/1944.

Immediate cause of death Acute Dilatation Heart Dis

Due to Enlarged Arteriosclerosis

Due to

Other Conditions Carcinoma of Stomach

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. P. Friedman, M.D.

Address 1319 Eutaw St. Date signed 4/29/44

G 16717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G 16717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E. Madison St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HILLIARD CROSBY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife Carrie P. Crosby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 21 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Chester S. Car.
(Town, county, and state)

10. Usual Occupation Sparrows Pt.
11. Industry or business Labourer

FATHER
12. Name Mont Crosby
13. Birthplace S. Car.

MOTHER
14. Maiden Name Nancy Young
15. Birthplace South Carolina

16 (a) Informant Mrs Carrie P. Crosby
(b) Address 1817 E. Madison St

17 (a)..... (Burial, cremation, or removal) (b) Date thereof 5-6-44 (month) (day) (year)
(c) Cemetery or crematory Chester
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 1 S. Druid Hill Ave.

19 (a)..... (b) Huntingtown, Md.
(Date rec'd by registrar) Registrar

MAY 1 - 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 7P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of chest

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-29-44 at 5:45 P. M.
(b) Where did injury occur? In front 1817 E Madison St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury knife - altercation

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.
Date signed 4-30-44

Write the causes of death clearly and legibly. Physicians: please write the ... important.

BRANDAU

C 16718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C 16718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town state, write RURAL, if give town)
(d) Street No. 544 S. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Brandau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Emma Harmon Brandau (If widow, give age years)

7. Birth date of deceased (mo., day, yr.) Jan 6, 1863

8. AGE: Years	Months	Days	If less than one day
81	3	18	hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Theresa Schneider
(b) Address 544 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Melville
Location Elkridge

18 (a) Funeral director Easton Sons
(b) Address 608 Fredericks Ave Catonsville Md

(a) APR 1 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1944 at 1:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage.

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed April 24, 1944.

G 16719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 a

Registered No. G 16719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flint Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Creasmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George R. Mathes

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara M. Mathes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/21/873

8. AGE: Years 70 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name Jacob H. Mathes
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Prescht
15. Birthplace Germany

16 (a) Informant Clara M. Mathes
(b) Address 3008 Creasmont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Road

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1960 Eutaw Place

19 (a) MAY 1 - 1944 (Date rec'd by registrar) (b) Wentz C. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of back (1, 2nd 3rd & 4th) lumbar Vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/6

(a) Date of injury April 17, 1944 M.
(b) Where did injury occur? 3008 Creasmont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
Means of injury Fall down stairs at home

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 29, 1944

16720

No. 487468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G 16720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Kight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1869

8. AGE: Years 75 | Months -0- | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Kight
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Duckworth
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 1-1944 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location

18 (a) Funeral director Robert S. Little
(b) Address 2702 Edmondson Ave

MAY 1 - 1944 (Date rec'd by Registrar)

19 (a) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1944 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944, to 4-25 1944, and that I last saw him alive on 4-25 1944

Immediate cause of death	Duration
Ca Liver - Metastasis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald Fitzpatrick M. D.
Address Balto City Hosp Date signed 4-31-44

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 16721 Registered No. 920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 Warren Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Warren Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas E King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mande
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1874

8. AGE: Years 69 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Friendship AA Co Md (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Emory King
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Tayman
15. Birthplace Md.

16 (a) Informant Mrs Maryonie M King
(b) Address 214 Warren Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director William M Moreck
(b) Address 715 Light St

19 (a) (Date rec'd by registrar) (b) Registrar
MAY 1 1944 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944, at 7:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1944, to 4-28 1944, and that I last saw him alive on 4-27 1944

Immediate cause of death	Duration
Chronic Myocardial Degeneration	1 yr.
Due to Arteriosclerosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Tolliod M. D.
Address 707 E. Fort Ave. Date signed 4-29-44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G 16722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 N. Patterson Park Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. O'Donnell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-14-3086

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1924

8. AGE: Years 19 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business Dixie Mfg Co

FATHER
12. Name Charles O'Donnell
13. Birthplace Penna.

MOTHER
14. Maiden Name Anna Houghton (Haughton)
15. Birthplace England

16 (a) Informant Mr. Carl J. Wright
(b) Address 744 N. Patterson Ave. #17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Filed MAY 1 - 1944 (b) Registrar Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1944, at 8:32 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944 to 4/30 1944, and that I last saw him alive on 4/30 1944

Immediate cause of death: Infarcts
Bacterial endocarditis

Due to Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Md. Gen. Hosp. Date signed 4/30/44

FILLING IN THIS CERTIFICATE, WRITE UNFADING INK. Answer all questions fully and correctly. Information should be carefully supplied. Accurate age is especially important. Physicians: please write the causes of death clearly and legibly.

16723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16723
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5606 Govane Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 Govane Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda E. Seward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: William H. Seward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5th 1864

8. AGE: Years 80 | Months 3 | Days 23 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

MOTHER / FATHER

12. Name: George Gehrmann

13. Birthplace:

14. Maiden Name: Louise Stoss

15. Birthplace: Germany

16 (a) Informant: Ada Dilworth

(b) Address: 5610 Govane Ave

17 (a) Burial (b) Date thereof 5/1/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~: London Park

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc

(b) Address: 1217 St. Paul st

MAY 1 - 1944 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28th 1944 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 4/28 1944, and that I last saw h[illegible] alive on 4/27 1944.

Immediate cause of death: Cerebral Sclerotic heart disease — Duration: 2 years

Due to:

Due to:

Other Conditions: Pernicious Anemia — 2 years.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible] M. D.

Address: 3[illegible] E Preston St. Date signed 4/29/44

PLEASE PRINT PLAINLY, WITH UNFADING INK. Entries must be complete and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 100

16724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

Registered No. G 16724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3833 Eighth St
(c) Hospital or institution: Baltimore 25 Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 25
(c) City or town Brooklyn Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3833 Eighth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Boy King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. min.

9. Birthplace Brooklyn Balto 25 Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oswin W. King
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ruby Baker
15. Birthplace North Carolina

16 (a) Informant Mr Oswin W. King
(b) Address 3833 8th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 (month, day) 44 (year)
(c) Cemetery or Location Cedar Hill Richie Highway Balto Md

18 (a) Funeral director Mathias Schilling
(b) Address 3916 Hanover St

19 (a) MAY 14 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1944 to — 19—.
and that I last saw h.r alive on April 30 19—.

Immediate cause of death premature separation of placenta (1466) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. W. Fowler
Address 302 Patapsco Ave. Date signed 5/1/44

VS 3

Please write the causes of death clearly and legibly. Physicians: please w... correct age is especially important.

G 16725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 16725 Registered No. 13B

YA

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 W. 36th Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MAY Audrey Bailey

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clarence F. BAILEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1916

8. AGE: Years	Months	Days	If less than one day
28	2	7	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William F. French
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice E. Gordon (d)
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof May 2-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Huntington Williamsport Md.
(Date rec'd by Registrar) Address

WH 1 - 544

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1944, at 6:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1944, to 4/29 1944, and that I last saw h[illegible] alive on 4/29 1944.

Immediate cause of death Pulmonary TBC — Duration

Due to

Due to

Other Conditions TBC laryngitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seymour M.D.
Address BCH Date signed 4/29

G 16725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 16725 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 Dolphin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William C. Armstead

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Armstead
13. Birthplace Va.

MOTHER 14. Maiden Name Jane Johnson
15. Birthplace Md.

16 (a) Informant Mr John W. Armstead
(b) Address 737 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b) Registrar

MAY 1 1944
150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 4-28-44 19 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10, 1944 to April 28 1944, and that I last saw h[illegible] alive on 4-28 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: Six Weeks
Due to: Arterio Sclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles T. Woodland M. D.
Address 9 E Hoffman St Date signed 4-29

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16727 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THEODORE R MURPHY

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruby E. Murphy
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) July 9, 1891

8. AGE: Years	Months	Days	If less than one day
52	9	20	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Coke Fireman
11. Industry or business

FATHER
12. Name Theodore D. Murphy
13. Birthplace West Indies

MOTHER
14. Maiden Name Laura C. Hegnacht
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Ruby E. Murphy
(b) Address 3901 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director G. L. Little
(b) Address 2700 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 1 - 1944 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenweber M.D.
Asst Medical Examiner.
Date signed 4-30-44

G 16728 ✓ G. 16728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 W LOMBARD STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 W LOMBARD ST.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ROSCOE GREASON SMITHSON

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 216-12-0720

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: ALMIRA
6 (c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) OCT 25-1880
8. AGE: Years 64 | Months 6 | Days 4 | If less than one day ____ hr. ____ min.
9. Birthplace HARFORD CO. (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business CON.

FATHER
12. Name JAMES SMITHSON
13. Birthplace HARFORD CO.

MOTHER
14. Maiden Name JENNIE SMITHSON
15. Birthplace HARFORD CO.

16 (a) Informant MRS. ALMIRA SMITHSON
(b) Address 1802 W LOMBARD STREET
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVENUE
18 (a) Funeral director C. RAYMOND KAUFMAN
MAY 1 1944 Address LEEDS AVENUE
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 64 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to April 29 1944, and that I last saw h in alive on April 2 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions Diabetes, Gangrene both feet	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Seagmeth M. D.
Address 1729 W Lomard Date signed 4/29/44

VS 3

G 16729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160C

G 16729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1340 S. Charles st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Palen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 - 1944.

8. AGE: Years | Months | Days | If less than one day 3 hr. 5 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Myron Palen
13. Birthplace Balto.

MOTHER
14. Maiden Name Emma Needer
15. Birthplace Balto.

16 (a) Informant Mrs. Needer
(b) Address 2430 E. Monument st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 1 44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto, Md

18 (a) Funeral director Philip Herring & Son
(b) Address 2024 Orleans st

19 (a) MAY 1 1944 (Date received by Registrar) (b) Registrar
VS 116 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at 8:22 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1944, to April 30 1944 and that I last saw h.. alive on April 30 1944.

Immediate cause of death Congenital Atelectasis — Duration —

Due to complicated Delivery with prolapsed cord — Duration 3 hours

Due to — Duration —

Other Conditions — Duration —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E Monument st Date signed 4/30/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16730 453798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

✓ G 16730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Presstman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Moses Clark.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Black.
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Bessie
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) 12-19-93
8. AGE: Years 50. Months 4 Days 8 If less than one day hr. min.
9. Birthplace Tenn. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

MOTHER / FATHER
12. Name Thomas Clark.
13. Birthplace N. C.
14. Maiden Name Jeddie ?
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary cem Location A. A. County Md
18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave
19 (a) May 1 1944 (b) Registered by Hunting to Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944, to April 27 1944, and that I last saw him alive on April 27 1944.

Immediate cause of death Cardiac Failure — Duration
Due to Hypertensive Cardio Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Hartzog M.D.
Address Johns Hopkins Date signed 4-28-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 16731

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16731 Registered No. 159

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bimy S Harper.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 2-26-44.
8. AGE: Years 0 | Months 2 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Wm A Kittrell
13. Birthplace D. C.

MOTHER
14. Maiden Name Henrietta Harper
15. Birthplace 1623 McCulloh St

16 (a) Informant Henrietta Harper
(b) Address 1623 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Peake
(b) Address 916 Pennsylvania ave

19 (a) (Date received by registrar) MAY 1 (b) 1944 Hunting [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944; at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944, to April 29 1944 and that I last saw h~~e~~ alive on April 29 1944

Immediate cause of death	Duration
Marasmus	
Due to Prematurity	
Due to Malnutrition	
Other Conditions 2 months	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ira H Pumphrey M. D.
Address 642 Druid Hill Ave Date signed 4-29-44

G 16732 ✓ G 16732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 100 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 Lyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES MAYNARD WHITE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 - 1899

8. AGE: Years	Months	Days	If less than one day
44	11	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Straw Hat Maker
11. Industry or business

FATHER
12. Name Harry Jno White
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine B. Schmidt
15. Birthplace Balto. Md.

16 (a) Informant Katherine White Mother.
(b) Address 3328 Lyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 - 1944 (month) (day) (year)
(c) Cemetery or crematory Westview Cemetery
Location Balto. Md.

18 (a) Funeral director Jno. E. Byer
(b) Address 1000 N. North Ave.

19 (a) Hunting for Williams, M.D. (Date rec'd by registrar) Registrar

MAY 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1944, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1944, to 4-28 1944, and that I last saw h.i alive on 4-28 19 44

Immediate cause of death	Duration
Pulmonary edema	
Due to Pneumonia, influenza	
Due to Arteriosclerotic H.D.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dwerk M. D.
Address Sinai Hosp. Date signed 4-29-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G 16733 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 326 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Elizabeth Kernan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28/1873

8. AGE: Years 70 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Thomas Kernan

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary A Quinn

15. Birthplace Baltimore Md

16 (a) Informant H. Gertrude Fairbanks

(b) Address 4307 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3/1944 (month) (day) (year)

VIII. Cemetery or crematory Mem Cathedral

Location Baltimore Md

18 (a) Funeral director Barry A. Amacost

(b) Address 4204 Ridgewood Ave

19 (a) (Date rec'd by Registrar) (b) (Registrar)

MAY 1 - 1944 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1944, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944, to 4/30 1944, and that I last saw h CF alive on 7/30 1944.

	Duration
Immediate cause of death: Hemorrhage	
Due to: Blood loss of	
Due to: Ca of Rectum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A H Bryce M. D.

Address Date signed

Dr. James R. Hubbard

G 16734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

G 16734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 McElderry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 McElderry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Harold Davis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16 1903

8. AGE: Years	Months	Days	If less than one day
41 40	1	11	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Pinkey Davis Sr.
13. Birthplace N.C.

MOTHER
14. Maiden Name Sally Howard
15. Birthplace N.C.

16 (a) Informant Pinkey A. Davis Jr.
(b) Address 1323 N. Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 29 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston Street

19 (a) 1944 (b) Registrar
(This field to be filled in by Registrar)

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 27 1944 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1944 to 4/27 1944 and that I last saw him alive on 4/27 1944.

Immediate cause	Duration
Paralytic Stroke	
Apoplexy	
Due to Thrombosis	
Due to probably work	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. R. Baker M.D.
Address 327 N. Charles Date signed 4/28/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Joseph L. MINTON

16735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave Balto
(c) Hospital or institution: Jenkins Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph L. Minton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna De Hart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16 1879

8. AGE: Years 65 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Patrick Minton

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Foley

15. Birthplace Ireland

16 (a) Informant Mrs. Jos A. McMahon

(b) Address 726 E. 30th St.

17 (a) Burial (b) Date thereof 5/2/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director C. D. Fanning & Son

(b) Address 1938 E. Lafayette Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mfg Registrar

MAY 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944 at 4.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1942 to April 29 1944, and that I last saw him alive on April 26 1944.

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo Arthur Romberg M.D.

Address 11 E. Lenox Road Date signed 5/2/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16736 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulkens & Eaton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Baby Boy Agganis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/44

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harry Agganis
13. Birthplace Greece

MOTHER 14. Maiden Name Stella Skoufalos
15. Birthplace Greece

16 (a) Informant Harry Agganis
(b) Address 1201 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Martin Lahey & Sons
(b) Address 1827 N. North Ave.

19 (a) MAY 1 - 1944 (Date received by registrar) Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1944, at 8:45 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 19 to 4/29 1944, and that I last saw him alive on 4/29 1944

Immediate cause of death Atelectasis. — Duration

Due to Prematurity

Due to Placenta previa.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4.29.44.
Major findings of operation: Placenta previa.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dudley P. Bowe M. D.
Address 2 W. Read St Date signed 5.1.44.

G 16737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 16737 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 S. Charles St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 S. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas O'Hara

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 220-03-2564

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Anne H. O'Hara
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.): May 10, 1883

8. AGE: Years	Months	Days	If less than one day
60	11	20	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Shipping Clerk
11. Industry or business Dept Store (Grants)

FATHER
12. Name Patrick A. O'Hara
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna E. Scheeler
15. Birthplace Ashland, Md.

16 (a) Informant Mrs. Anna H. O'Hara
(b) Address 3703 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Hunting for Veterans, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1944 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above; and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Walter L. Tilden M.D.
Medical Examiner.
Date signed 5/3/44

G 16738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G 16738 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Jasper Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 189[illegible]

8. AGE: Years	Months	Days	If less than one day
49	4	11	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Washington D. C.

MOTHER
14. Maiden Name Mary
15. Birthplace St. Mary's Co.

16 (a) Informant Annie Hairston
(b) Address 609 Que St. N.W. Wash.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151 1944 Hunter Jr. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21- 1944 at 9[illegible] P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck involving vessels.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-21- at 9 M.
(b) Where did injury occur? 519 Jasper Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Walden M.D.
Medical Examiner.

Date signed 4-22-44

G 16739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Walnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1115 Walnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Fritzges

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Josephine M. (nee Schmaing) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1885.

8. AGE: Years 59 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Asst. Paymaster

11. Industry or business B.&O.R.R., retired 2 yrs.

FATHER
12. Name Frederick Fritzges
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Sussan
15. Birthplace Baltimore, Md.

16 (a) Informant Joseph F. Fritzges
(b) Address 1115 Walnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2/44. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Meitzler
(b) Address 4101 Edmondson Ave.

19 (a) MAY 1 - 1944 (Date rec'd by registrar) Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28/44 19 49, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 19 43, to Apr. 28 19 44, and that I last saw him alive on Apr. 27 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Ave. Date signed 4/29/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16740
JL - 85044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16740
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1881

8. AGE: Years 62 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Levin Anthony
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Gustay
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Charles B. Cooper
(b) Address 5[illegible] Carrollton Ave.

19 MAY 1 - 1944 (Date rec'd by registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1943 to 4-26 1944, and that I last saw h[illegible] alive on 4-26 1944.

	Duration
Immediate cause of death: Intussusception	
Due to: Hypertensive cardiovascular disease	1
Due to: Pneumonia	1
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattman M. D.
Address B. C. H. Date signed 4/26/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G 16741 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 Spring Ct. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William Hunter

3 (b) If veteran, name war. | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-00

8. AGE: Years	Months	Days	If less than one day
43	10	24	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Chemical Operator
11. Industry or business

FATHER
12. Name John Hunter
13. Birthplace N.C.

MOTHER
14. Maiden Name Frances Williams
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County
18 (a) Funeral director Mrs. Robert A. Elliott & Dgt.
(b) Address 1129 N. Caroline St.

MAY 1 - 1944 (Date rec'd by registrar) Hunting to Williams Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944 at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 28 1944 to April 30 1944 and that I last saw [illegible] alive on Apr. 30 1944

Immediate cause of death	Duration
Bronchogenic carcinoma	
Due to Ca of the lung - lymph	
Due to node metastases	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.....
23. Signature John R. Birmingham M.D.
Address JHH Date signed 5/1

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16742 Registered No.

v 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1890

8. AGE: Years 50 | Months - | Days 28 | If less than one day hr. min.

9. Birthplace Roncevarte W. Virginia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not known

13. Birthplace "

MOTHER 14. Maiden Name Not known

15. Birthplace "

16 (a) Informant George Williams

(b) Address 343 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)

(c) Cemetery or crematory

Location Roncevarte, West Virginia

18 (a) Funeral director Mrs. Frances H. Hemsley

(b) Address 518 W. Biddle St

19 (a) (Signature) (b) Hunter Williams, M.D. (Address)

MAY 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 8 33 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1943, to April 29 1944, and that I last saw h 84 alive on April 29 1944.

Immediate cause of death: Arteriosclerosis — Duration

Due to

Due to

Other Conditions: Diabetes Mellitus, Left Hemiplegia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G H Bayne

Address Roncevarte Hospital Date signed 5/1/44

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 16743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 16743

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 Argyle ave
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Argyle ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Massey

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Baltimore MD.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Horace Bias
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Ann Boston
15. Birthplace Md.

16 (a) Informant M's Bertha Bias
(b) Address 1131 Argyle Ave.

17 (a) Buria; (Burial, cremation, or removal) (b) Date thereof 5-4-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) MAY 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1- 1944 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 5-1-44

G 16744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16744
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 N. Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME ~~Cosmas~~ Cosmas ~~Lykos~~ LyKos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Angeline Lykos

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 10/14/~~1895~~ 1896

8. AGE: Years ~~48~~ 47 | Months 4 | Days 1 ~~5~~ | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name Nick Lykas
13. Birthplace Greece

MOTHER
14. Maiden Name
15. Birthplace Greece

16 (a) Informant Mrs Lydodemas
(b) Address 2356 E North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Catholic Cemetery
Location Windsor Mill Road

18 (a) Funeral director Wooten Brooks Bendelyne
(b) Address 1922 E North Ave

19 (a) (Date received by registrar) (b) Emily Williams, M.D. Registrar

MAY 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1944 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ~~X~~, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of heart

Due to Coronary thrombosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 28 1944

(over)

Correct age is extremely important. Physicians: please write the

G 16745 G 16745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1018 Hollen St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Hollen St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lillie Ogburn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colld | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Penky Ogburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name John Harper
13. Birthplace N.C.

MOTHER: 14. Maiden Name Elizabeth
15. Birthplace N.C.

16 (a) Informant Mattie Allen (Daughter)
(b) Address 1018 Hollen St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

VS MAY 1 - 1944 Deputy for Hillman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 9:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1944 to April 29 1944, and that I last saw her alive on April 29 1944.

Immediate cause of death Bronchopneumonia — Duration 3 days
Due to Myocarditis
Due to Myocardial Degeneration
Due to Chronic Nephritis
Other Conditions

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Lapides M. D.
Address 822 N. Bond St Date signed 5/1/44

16746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G 16746

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Mae Cummings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 3 | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jerome Cummings
13. Birthplace

MOTHER
14. Maiden Name Gertrude Parrish
15. Birthplace

16 (a) Informant Jerome Cummings
(b) Address 30 E. Hamburg St.

17 (a) (Burial, cremation, or removal) (b) Date thereof May 3 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Wyed Rd

18 (a) Funeral director Limbert Inc
(b) Address 4149 Harcum Lintown Rd

19 (a) (Permit to bury issued) (b) Registrar

MAY 1 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944 to 4/30 1944, and that I last saw her alive on 4/30 1944.

Immediate cause of death	Duration
Respiratory Failure	
Dehydration	
Due to Nutritional Diarrhea	4 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Liberle M. D.
Address University Hospital Date signed 4/30/44
Redwood & Greene St.

G 16747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16747
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Paulskin
(c) Hospital or institution: Bon Secours Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 Poplar Grove (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maine Allen Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1888

8. AGE: Years 56 | Months 2 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Penna (Town, county and state)

10. Usual Occupation Stationary Engineer

11. Industry or business

FATHER
12. Name John Campbell
13. Birthplace Penna

MOTHER
14. Maiden Name Mat Arabella
15. Birthplace Penna

16 (a) Informant Mrs Michael Campbell
(b) Address 1231 Poplar Grove

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Joseph Farley
(b) Address Fulton & Fayette

19 (a) ..... (Date received by registrar) (b) ..... Registrar

MAY 1 1944 Huntingdon Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1944, at 4 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944 to 4/30 1944 and that I last saw him alive on 4/30 1944

Immediate cause of death Hemorrhage — Duration

Due to Ruptured aneurysm — 2 days
Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Poyer M. D.
Address Bon Secours Hosp Date signed 4/30/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16748 G 16748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ocho Calder

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marguerite Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 13, 1896

8. AGE: Years 47 Months 4 Days 17 If less than one day hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Fairfield Shipyard

FATHER
12. Name Clarence Calder
13. Birthplace Harford County

MOTHER
14. Maiden Name Rebecca Glenn
15. Birthplace Harford County

16 (a) Informant Marguerite Calder
(b) Address 1806 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3-44 (month) (day) (year)
(c) Cemetery or crematory Centre Forest Hill Cemetery
Location Forest Hill Cemetery Rd.

18 (a) Funeral director Maurice E. Hunter
(b) Address Lanvale & Howard Sts.

MAY 1 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION 55

20. DATE OF DEATH May 1, 1944, at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon Monoxide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-30-44 at M.
(b) Where did injury occur? 1805 N. Durham St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Was gas on but unlit.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 1 1944

G 16749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16749 Dr Mem

Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 75

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Frank C Schwartze sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
75	—	—	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Decorator

11. Industry or business for Windows

FATHER 12. Name Frank Schwartze

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Ann Bleuten

15. Birthplace Germany

16 (a) Informant Mrs Frank C Schwartze

(b) Address 2003 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery

Location —

18 (a) Funeral director Mary M Woodfield

(b) Address 501 E 22nd St

(Date) 1944 (Registrar) Hunting for Williams M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944 at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to April 29 1944 and that I last saw him alive on April 29 1944

Immediate cause of death Cardiac Insufficiency — Duration

Due to —

Due to —

Other Conditions Chr Nephritis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Carlton C Mowbray M.D.

Address 501 E North Ave Date signed 5/1/44

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

✓ G 16750 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5821 Royal oak ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5821 Royal oak ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Catherine LaFevre

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Walter H. LaFevre

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2-1876

8. AGE: Years 68 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Philadelphia Pa
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Wm. C. Hewitt

13. Birthplace Unknown

MOTHER: 14. Maiden Name Jane E. McManus

15. Birthplace Pa.

16 (a) Informant Mrs W. Stanley Allen

(b) Address 5821 Royal Oak ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2-44 (month) (day) (year)

(c) Cemetery or crematory Loving Hill Cem.

Location Easton Md

18 (a) Funeral director Geo. L. Berger Jr

(b) Address 15½ Holliday St

19 (a) (Date received by registrar) MAY 1 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944 at 3a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1944 to April 30 1944 and that I last saw h alive on April 30 1944

Immediate cause of death

Pancreatitis Duration: Indef

Due to Breast Ca

Due to —

Other Conditions Thrombosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)

(e) Means of injury —

23. Signature Huntington Williams M.D.

Address 1720 W. 25th Date signed May 1 1944

C 16751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. C 16751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hudson Rd
(c) Hospital or institution:
Stevens Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Curson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie G. Pollock

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Chas. A. Pollock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1860

8. AGE: Years 83 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Penn Dutchman (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John A Graham
13. Birthplace Baltimore

MOTHER
14. Maiden Name Adelaide ?
15. Birthplace Germany

16 (a) Informant Carl Pollock
(b) Address 3312 Seymour

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) MAY 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH April 30 1944; at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1944, to Apr 30 1944, and that I last saw h[illegible] alive on Apr 29 1944.

Immediate cause of death	Duration
Acute Bronchitis	7 D.
Bronchial Pneumonia	3 D.
Due to Cerebral Hemorrhage	6 mo
Due to Chronic Nephritis	6 mo
Other Conditions Ch. Int. Nephritis	6 mo

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T F A Stevens
Address 2878 Hartford Ave Date signed 5-1-44

16752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 16752
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct: age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 E Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Urbancik

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1878

8. AGE: Years 66 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Cabinet Maker Retd

11. Industry or business

FATHER 12. Name Joseph Urbancik
13. Birthplace Austria

MOTHER 14. Maiden Name Mikonova
15. Birthplace Austria

16 (a) Informant George F Urbancik
(b) Address 2203 Cuntiss Place

17 (a) Burial (b) Date thereof 5/4/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Colyer Inc
(b) Address 1217 E Fort Ave

MAY 2 - 1944
(Date rec'd by registrar) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944 at 3 G M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1941 to May 1 1944 and that I last saw him alive on 4/28 1944.

Immediate cause of death	Duration
Coronary Thrombosis	sudden
Due to arteriosclerotic cardiovascular Disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Karl Grossman M.D.
Address 1220 N Patterson Park Ave Date signed 5/1/44

G 16753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

Registered No. G 16753

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 N. Charles st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brogna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 26th 1943

8. AGE: Years	Months	Days	If less than one day
	6	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Brogna
13. Birthplace Boston Mass

MOTHER
14. Maiden Name Margaret Kiernan
15. Birthplace Balto Md

16 (a) Informant Thomas Brogna
(b) Address 1217 N. Charles St

17 (a) Burial (b) Date thereof 5/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (Date rec'd by Registrar) MAY 2 - 1944 Registrar for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1944, to April 30 1944, and that I last saw h[illegible] alive on April 29 1944

Immediate cause of death: Acute Miliary Tuberculosis — Duration: 2 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred Hermann M. D.

Address 1934 Wilkens Date signed 5/1/44

G 16754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G 16754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Woodbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Greenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Re becca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 29, 1888

8. AGE: Years 55 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Merchant

FATHER
12. Name Jacob Greenfeld
13. Birthplace Russia

MOTHER
14. Maiden Name Cecelia ?
15. Birthplace Russia

16 (a) Informant Jesse Greenfeld
(b) Address 3501 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1944 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

MAY 2 1944 (Date rec'd) Hunting to Williams Mort

VS 150

MEDICAL CERTIFICATION

5.45

20. DATE OF DEATH May 1, 19, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from apr-10 1944 to May-1 1944, and that I last saw him alive on apr 30 1944.

Immediate cause of death: Gastric Carcinoma — Duration: 1 yr.

Due to:

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Greenfeld M. D.

Address 122 w Lee Date signed 5/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139a

G 16755 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 N. Howard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Gaylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-08

8. AGE: Years 35 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name James Thornton
13. Birthplace Va
14. Maiden Name Mary Jackson
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal Shipping (b) Date thereof (month) May (day) 3 (year) 1944
(c) Cemetery or crematory Gloucester Cemetery
Location Gloucester Co Va.

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 MAY 2 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1944 to April 29 1944 and that I last saw her alive on Apr 29 1944

Immediate cause of death Anaesthesia

Duration

Due to Abdominal abscess, multiple

Due to Ruptured tubo-ovarian abscess, left

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-29-44

Major findings of operation: as above

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence (month) (day) M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin H. Davis, M. D.
Address Johns Hopkins Date signed 4-29-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

G 16756 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 8 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 N. Milton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda S. von Kennen Von Kennen

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1914

8. AGE: Years 29 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Frederick A Von Kennen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Katherine Bis Loff
15. Birthplace Baltimore

16 (a) Informant Frederick Von Kennen
(b) Address 1702 N Milton ave

17 (a) Burial (b) Date thereof May 3 / 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Comm
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Monument St

19 (a) MAY 2 - 1944 Attesting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30-1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Chest & Pelvis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-30-44 at 1.40 P M.
(b) Where did injury occur? Ford Balto. Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped from roof to street

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 5-1-44

VS 151

16757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

✓ G 16757

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 N. Luzerne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 N. Luzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ~~LEIGH~~ Leyh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Johannah Leyh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1871

8. AGE: Years 72 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace ~~Ba~~ Germany (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Adam Leyh
13. Birthplace Ger

MOTHER
14. Maiden Name
15. Birthplace Ger

16 (a) Informant Herman Leyh
(b) Address 1326 N Luzerne

17 (a) Loudon Park (Burial, cremation, removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Burial
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. 8 Arlean

19 (a) (Date received by registrar) MAY 2 1944 (b) Huntington Williams M.D.

VS 15-1

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Attending Medical Examiner.
Date signed 4-30-44

(OVER)

KANSLER ✓

C 16758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C 16758 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1030 Mc Lean Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Mc Lean Court
McAlen (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

✓

3 (a) FULL NAME Clementine Kansler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Henry H. Kansler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1862

8. AGE: Years 82 | Months 2½ | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Stephen D. Cook
13. Birthplace New Jersey

MOTHER
14. Maiden Name Alice Walker
15. Birthplace Md

16 (a) Informant Edgar Kansler
(b) Address 1030 McLean Court

17 (a) Burial (b) Date thereof May 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) (b)
(Signature of registrar) (Registrar)

MAY 2 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1944, to 4/28 1944 and that I last saw her alive on 4/28 1944.

Immediate cause of death Acute Bowels Pneumonia Primary — Duration

Due to Ch. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Homstein
Address 733 Augusta St Date signed 5/1/44

G 16759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G 16759 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 656 Pitcher St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 656 Pitcher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cordelia (Odelia) Sheppard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widowed

6 (b) Name of husband or wife Geo Sheppard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1874

8. AGE: Years	Months	Days	If less than one day
69	10	21	hr. min.

9. Birthplace Portsmouth, Va. (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Nathan Bizzle
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Cornelius C. Sheppard
(b) Address 656 Pitcher St

17 (a) Burial (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Churchland Cem
Location Churchland Va

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave Hunting for William A Jackson

19 (a) (Date received by registrar) (b) Registrar

VS 1 MAY 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 1944, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1944 to May 1 1944, and that I last saw him alive on May 1 1944.

Immediate cause of death	Duration
Pulmonary edema	2 days
Due to, Chronic Nephritis	6 mos.
Due to, Chronic Myocarditis Scarlatina	6 mos.
Due to, Arteriosclerosis	8 mos.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Nature of injury

Signature Wm. LeRoy Berry M. D.
Address 420 E. Chase Date signed May 1 '44

Correct age in especially important cases. Physicians: please write the causes of death clearly and legibly.

G 16760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G 16760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4949 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 1 day. 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 N. Bentelou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Welling Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1861

8. AGE: Years	Months	Days	If less than one day
82	6	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joshua - FISHER
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Warfield
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) BURIAL (b) Date thereof MAY-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. HOPE WOODSBORO MD
Location WOODSBORO · MD

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 E. UTAW PLACE

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 2 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29 1944, at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1944, to 4-29 1944, and that I last saw ~~him~~ alive on 4-29 1944.

Immediate cause of death	Duration
Ca Bladder	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald B Watt M. D.
Address Balto City Hosp Date signed 4-29-44

G 16761
53166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 13B

G 16761
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Cambridge (If outside city or town limits write RURAL and give town)
(d) Street No. 29 Cemetery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sammy Kaye Shorter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-21-43
8. AGE: Years | Months: 6 | Days: 11 | If less than one day: hr. min.
9. Birthplace Md. (Town, county, and State)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Granville Shorter
13. Birthplace Md.

MOTHER
14. Maiden Name Muriel Airey
15. Birthplace Md.

16 (a) Informant Recorde
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Dorchester Mem. Pk.
Location Cambridge Md.

18 (a) Funeral director L. Caulk Funeral Dir.
(b) Address Cambridge, Md.

19 (a) (Date rec'd by registrar) (b) Huntingtn Williams M.D.
MAY 2-1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to May 1 1944 and that I last saw deceased alive on May 1 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: Tuberculosis — over
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp. Date signed 5.3.44

Correct age is especially important. Physicians: please write the

G 16762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 16762 Registered No.

PLEASE WRITE PLAINLY with pencil or pen and ink. Physicians: please write the causes of death clearly and legibly. Give the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 S PACA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. James R. Woolmer SR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Elizabeth.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 26 1861

8. AGE: Years 83 Months 1 Days 5 If less than one day hr. min.

9. Birthplace Baltimore. (Town, county, and state)

10. Usual Occupation None -

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Not known

MOTHER 14. Maiden Name Not Known

15. Birthplace Not Known

16 (a) Informant Elizabeth Woolmer

(b) Address 921 S Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto Md

18 (a) Funeral director Edmund C Hanley

(b) Address 121 E Mt St

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1- 1944, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24-44 19 44 to 5-1 1944, and that I last saw h.l alive on 5-1 19 44.

Immediate cause of death	Duration
(a) Acidosis - Uremia.	
Due to (b) Postoperative Amputation of Rt. Leg -	
Due to (c) Arteriosclerotic Gangrene of Rt. leg	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation 4-20-44

Major findings of operation: Same -

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klymowicz

Address St Joseph's Hosp Date signed 5/2/44

112 31T. Pearl St.

No. From 10763 G 16763

✓ G 16763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Howrick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Howrick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Cross.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Wm. R. Cross.
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 20, 1874

8. AGE: Years 69 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Martin
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary A. Howard.
15. Birthplace Maryland.

16 (a) Informant Wm. R. Cross.
(b) Address 2904 Howard Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Thanhouser & Donovan
(b) Address 3615-17 Eastern Ave. Hunting for Williams, M.D.

19 (a) (Signature of registrar) (b) Registrar

MAY 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1944, at 5:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to May 1 1944, and that I last saw her alive on April 30 1944

Immediate cause of death Acute Cardiac failure — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Thanhouser
Address 1123 Hanover Date signed May 2 1944

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Give correct age is especially important.

G 16764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 16764 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 Webster St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Webster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Virginia Thomas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Richard Robbins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1860

8. AGE: Years: 83 82 | Months: 5 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: Richard Robbins
13. Birthplace: Dorchester Co, Md.

MOTHER
14. Maiden Name: Mary Virginia ?
15. Birthplace: Dorchester County, Md

16 (a) Informant: Howard E. Thomas (Son)
(b) Address: 1325 Webster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/3/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Ave

18 (a) Funeral director: Earl L. Hess
(b) Address: 715 Light St.

19 (a) (b) Huntington Williams, Registrar

NOV 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/44 19 at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to 5/1 19 44.
and that I last saw her alive on 4/29 19 44

	Duration
Immediate cause of death: Coronary occlusion	1 day
Due to: Arteriosclerosis	4 years
Due to:	
Other Conditions: Chronic hypocardiac with mitral insufficiency (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Isaac Mills M. D.
Address: 725 N. Charles St. Date signed: 5/4/44

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important.

G 16765

G 16765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

PLEASE WRITE the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Sparrows Pt. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 E. St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Roman Lerew

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-6159

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Etta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1883

8. AGE: Years 61 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Buyer

11. Industry or business

MOTHER / FATHER
12. Name Wm. Lerew
13. Birthplace Penna.
14. Maiden Name Jeanie Olson
15. Birthplace Penna.

16 (a) Informant Mary Etta Lerew
(b) Address 728 E. Sparrows Pt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director William M. Mareck
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAY 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1944 at 11:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1944 to 4/30 1944, and that I last saw h.2 m. alive on 4/30 1944

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 4/30/44

G 16766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16766

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Va~~ Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4850 Pimlico Road ft. 15
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clara V Crowther

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	w	m

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1/1876

8. AGE: Years	Months	Days	If less than one day
67	8		hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles B. Kent
13. Birthplace Maryland

MOTHER
14. Maiden Name Eugenia Haynie
15. Birthplace Virginia

16 (a) Informant Evelyn F. Humphries
(b) Address 4850 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4/1944 (month) (day) (year)

(c) Cemetery or crematory Loudon
Location Avalon Va

18 (a) Funeral director Harry G. Annacost
(b) Address 4204 Edgewood Ave

19 (a) MAY 2 - 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1944, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1944, to 5-1 1944, and that I last saw h~~e~~ alive on 5-1 1944.

Immediate cause of death	Duration
Myocardial failure (Taylor)	
Due to Diabetic gangrene	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-10-44, 4-29-44

Major findings of operation: gangrene of right foot

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John DeJarnette Jr. M.D.
Address Med. Gen. Hosp. Date signed 5-1-44

G 16767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 16767 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 1
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 St. Paul (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary J. Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lt. Exster Williams

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1879

8. AGE: Years 65 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Wife

11. Industry or business

FATHER 12. Name Calvin Cunningame

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary E. Burrucker

15. Birthplace Maryland

16 (a) Informant Mrs. Harry L. Weikert

(b) Address 3022 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director H. W. Mears & Son

(b) Address 805 N. Calvert St.

19 (a) (b) Huntington Millersville, Md.

MAY 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29 1944 at 6 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1944 to 4-29 1944, and that I last saw her alive on 4-29 1944.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Adeno-Carcinoma of Sigmoid	?
Due to	
Due to	
Other Conditions Arteriosclerosis, generalized.	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Armstrong Jr. M. D.

Address 332 E. University Pkwy. Date signed 4/29/44

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G 16768 ✓ G 16768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Dorchester Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits write RURAL and give county)
(d) Street No. 3810 Dorchester Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Awrach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER: 12. Name Morris Perl
13. Birthplace Russia

MOTHER: 14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Max Awrach
(b) Address 3810 Dorchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V-2-44 (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 609 E. Balto St

19 (a) MAY 2 1944 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1943 to May 1 1944, and that I last saw h alive on May 1 1944

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Arteriosclerosis — Duration ?

Due to Hypertension Nephritis — Duration ?

Other Conditions Myocardial insufficiency — Duration 6 mos ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.
Address 1004 Linden Ave Date signed 5/3/44

correct age in especially important cases. Advertising, press notices, etc.

G 16769 ✓ G 16769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution:
Church Home + Hospital 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 East Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Maley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1899

8. AGE: Years	Months	Days	If less than one day
45	1	4	hr. min.

9. Birthplace Sparrows Point, Md.
(Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Thomas Maley
13. Birthplace Ireland

MOTHER
14. Maiden Name Ulia Hunter
15. Birthplace Ireland

16 (a) Informant Hospital
(b) Address Record.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4th 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director John C. Moran
(b) Address 3600 Baltimore St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MAY 2 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944, to May 1 1944, and that I last saw him alive on May 1 1944.

Immediate cause of death	Duration
Bronchogenic Carcinoma	?
2 Metastasis to Liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L.L. Loesberg M. D.
Address Church Home & Hosp Date signed 5/1/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C 16770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 547 Laurens St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 547 Laurens St. (If rural state location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jillian Johnson (Jones)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abraham Johnson
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 12, 1902

8. AGE: Years 41 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Robertson
13. Birthplace Va

MOTHER
14. Maiden Name Sally Tyson
15. Birthplace Va.

16 (a) Informant Abraham Johnson
(b) Address 547 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave.

19 (a) MAY 2 - 1944 (Date rec'd by registrar) Huntley & Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 29 19 44, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 19 43 to Apr 29 19 44, and that I last saw h[illegible] alive on Apr 28 19 44.

	Duration
Immediate cause of death Edynic Bronchial Asthma	?
Due to Cardio Vascular Disease	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Fier M. D.
Address 928 Howard Date signed 5/1/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03020 G 16771 BALTIMORE CITY HEALTH DEPARTMENT G 16771
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Luster
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: black
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Daniel Luster
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) 8-20-09
8. AGE: Years 34 | Months 8 | Days 10 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Joseph Jones
13. Birthplace Md

MOTHER
14. Maiden Name Clara Campbell
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Elroy Wilson
(b) Address 6000 Baltimore
19 (a) MAY 2 1944 (Date rec'd by Registrar) (b) Harding Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 44 at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to April 30 1944 and that I last saw h[illegible] alive on April 30 1944

Immediate cause of death: Hypertensive cardio-vascular disease — Duration

Due to: hypertensive encephalopathy

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Birmingham M. D.
Address JHH Date signed 4/30

G 16772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16772 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 Ensor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Ensor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine R. Guessaer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: James R. Guessaer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9. 1875

8. AGE: Years 68 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER — 12. Name Charles Boone
13. Birthplace Md

MOTHER — 14. Maiden Name Mary Fraud
15. Birthplace Germany

16 (a) Informant Mary E. Boone
(b) Address 4101 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Ave

19 MAY 2 - 1944 (Date rec'd by Reg.) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944, to May 1 1944, and that I last saw h[illegible] alive on May 1 1944

Immediate cause of death: Broncho Pneumonia — Duration 2 d.
Due to Mitral regurgitation — 3 d.
Due to Chr. Interstitial nephritis — 5 d.
— 5 d.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I Sa Stevens
Address 2878 Harford Av Date signed 5-1 44 M. D.

G 16773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16773 Registered No. 1354

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside the city or town limits, write RURAL and give town)
(d) Street No. Route 10 Box 341 Denton Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Mamie Parkent (Mamie F. Parkent)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Wm Parkent
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/9/1895

8. AGE: Years 49 | Months 1 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Harry J. Clark
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth Anderson
15. Birthplace Va.

16 (a) Informant Mr. William Parkent
(b) Address Route 10, Box.341, Sparrows Pt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 2 - 1944 (Date rec'd by registrar) (b) [illegible] Baltimore, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1944, to 5-1 1944 and that I last saw h cr alive on 5-1 1944

Immediate cause of death Pulmonary Embolism — Duration

Due to Thrombosis of pelvic veins

Due to Repair of femoral hernia,

Other Conditions Carcinoma, cervix + amputation of cervix
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Pulmonary embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Leahy M.D.
Address Fr-Sq. Hosp Date signed 5/1/44

16774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

C 16774 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 348 Whitridge Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 348 Whitridge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILLIE CLARA TRIMBLE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Glenn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 3, 1868

8. AGE: Years: 76 | Months: 0 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Roth
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Pfluger
15. Birthplace: Germany

16 (a) Informant: Mr. Charles Glenn Trimble
(b) Address: 348 Whitridge Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/3/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

MAY 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1944 at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1944 to May 1 1944 and that I last saw h.. alive on April 30 1944

Immediate cause of death — Cardiovascular Renal Disease — Duration

Due to

Due to

Other Conditions Apoplexy - 14a ago — 14a

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature: Nathaniel M Beck M. D.
Address 2727 N. Charles Date signed May 1-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

16775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1226

Registered No. G 3 16775

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County Hall
(c) City or town Memphis (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Winfred Wilson

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Hulda Cannon

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 3 1879

8. AGE: Years 64 | Months 6 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Boonville, Texas (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Dr. C. F. Wilson
13. Birthplace Missouri

MOTHER
14. Maiden Name Mollie Rector
15. Birthplace Missouri

16 (a) Informant Mrs. Hulda Wilson
(b) Address Memphis, Texas

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/2/44 (month) (day) (year)
(c) Cemetery or crematory
Location Memphis, Texas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 2 - 1944 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 7:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1944, to 5-1 1944, and that I last saw h in alive on May 1 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Occlusion	
Due to Obstruction of large colon	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-25-44

Major findings of operation: Many adhesions obstruction of large colon

of autopsy: peritonitis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chitwood M. D.

Address Union Memorial Hospital Date signed 5/1/44

16776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1930

G 16776
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2141 N. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2141 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAY A. DIXON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward A. Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Hillary
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ann O'Grady
15. Birthplace Md.

16 (a) Informant Mrs. Wilbur Pierce
(b) Address 2141 N. Pulaski St.

17 (a) Burial (b) Date thereof 5/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Registrar) Registrar

MAY 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to April 30 1944
and that I last saw h[illegible] alive on April 30 1944

Immediate cause of death — Duration

Cerebral Hemorrhage — 4 days
Due to Arteriosclerosis — 2 yrs
Due to
Other Conditions Chronic Myocarditis — 1 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed 5/1/44

G 16777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 469

G 16777 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

Since 2/25/44

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3310 Old Frederick Road

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME WILLIAM EDWARD GROH

3 (b) If veteran, name war: World's War

3 (c) Social Security Account No. ~~57-106-80~~ 212-05-9128

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Bopp GROH.

6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Feb. 29, 1896

8. AGE: Years	Months	Days	If less than one day
48	2	2	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Am.St.Lighting Co. (Laborer)

11. Industry or business:

FATHER

12. Name: Frank Groh

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden Name: Margaret Elizabeth Ring

15. Birthplace: Germany

16 (a) Informant: Records, U.S.Marine Hospital

(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May. 4-44. (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.

Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.

(b) Address 505 N. Monroe St.

19 (a) [illegible] (b) [illegible]

Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May 1, 1944, at 2:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1944, to May 1, 1944, and that I last saw him alive on May 1, 1944

Immediate cause of death: Carcinoma of the body of the pancreas with extensive metastases into the liver, lungs, both kidneys and about the common bile duct.

Duration: First noted pain 6 weeks prior to admission

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: 3/17/44-Exploratory laparotomy

Major findings of operation: Liver studded with carcinomatous nodules

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. S. Thom

Address Baltimore, Md. Date signed 5/1/44

16778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 837

G 16778
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 2nd St.
(c) Hospital or institution: ~
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 2nd St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Shelby

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M.
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Emma Shelby
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 16 1864
8. AGE: Years 79 Months 7 Days 14 If less than one day hr. min.
9. Birthplace Germany (town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Henry Shelby
13. Birthplace Germany

MOTHER
14. Maiden Name Don't Know
15. Birthplace Germany

16 (a) Informant Lena Wade
(b) Address 3602 2nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 1944 (month) (day) (year)
(c) Cemetery or crematory Leader Hill
Location A. A. County
18 (a) Funeral director Martin J. Conroy
(b) Address 1102 Forest St
19 (a) Date received 1944 (Registrar) Katherine Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944 at 2:25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944 to May 1 1944 and that I last saw him alive on April 30 1944

Immediate cause of death Pardpsis — Duration
Due to Bloodpressure &c, —
Due to —
Other Conditions Bronchial-Pneumonia
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓
23. Signature C. Hans, M. D.
Address 1216 Fairmount Date signed May 1 1944

16779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C-15779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5638 Belair Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5638 Belair Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Phillips

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Emma C. Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1862

8. AGE: Years 82 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Phillips
13. Birthplace Balto.

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Baker
(b) Address 5638 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 3 44 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Philip Herring Sons
(b) Address 2324 Orleans St

MAY 2 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 30 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13- 1938, to 4-30- 1944 and that I last saw him alive on 4-24- 1944.

Immediate cause of death: Cardio-vascular renal disease — Duration: 6 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin C. Lang M. D.
Address 2117 Belair Rd Date signed 5-1-44

G 16780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16780 Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or Baltimore County limits, write RURAL and give town)
(d) Street No. 4715 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Regent

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/44

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Regent
15. Birthplace Balto. City Md

16 (a) Informant Nicholas Regent
(b) Address 4215 Millbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 2 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 740 E. Belair Rd.

5-2-1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1944, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944 to 5/1 1944, and that I last saw h. alive on 5/1 1944

Immediate cause of death: Patent Foramen Ovale. — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Non P.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilbur A. Mitchell M.D.
Address Maryland General Hosp. Date signed 5/1/44

VS 150

Cause of death is especially important

G 16781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16781 Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 S. Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 S. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaw Rasinski

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Rasinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years: 51 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Iron Molder

11. Industry or business

FATHER
12. Name John Rasinski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Rose Rasinski
(b) Address 323 S. Chester St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) (Date rec'd by registrar) MAY 2 1944 Registrar

I certify correct age is especially urged.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944 at 7:40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944 to April 30 1944 and that I last saw h IM alive on April 30 1944

Immediate cause of death: DIABETES MELLITUS — Duration: 1940

Due to:

Due to:

Other Conditions: 1- ARTERIOSCLEROSIS — ??
2- INGUINAL HERNIA
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Deuga

Address 209 S. Chester St Date signed M. 5 D. 2/44

C 16782

AB-80505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1938

C 16782
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yr-5 mos- 28days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Correa, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 28- 1884
8. AGE: Years 59 Months 11 Days 2 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name John Correa
13. Birthplace Md.

MOTHER
14. Maiden Name Estelle Getzendanna or Getzendanner
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address - Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Northw. Balto. Md.
18 (a) Funeral director Paly & Mulligan
(b) Address 2415 E. Oliver St
19 (a) [illegible] Williams, M.D.

MAY 2 - 1944

VS 150

correct age in

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at 12.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/1 1943 to 4/30 1944, and that I last saw h[illegible] alive on 4/30 1944

Immediate cause of death Cerebral hemorrhage — Duration

Due to H.C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ruptured ulcer of stomach;

of autopsy: Imp. Hyperten. arteriosclerosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sayman M. D.
Address BCH Date signed 5/1

PHYSICIAN
Underline the cause to which death should be charged statistically.

16783 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 16783

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2335 Eutaw Place.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2335 Eutaw Place. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ISABEL M. COLEMAN.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1871.

8. AGE: Years 72 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Nathan Coleman,
13. Birthplace Bavaria.

MOTHER 14. Maiden Name Bettie Stein,
15. Birthplace Balto. Md.

16 (a) Informant Miss. Helene N. Coleman,
(b) Address 2335 Eutaw Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son.
(b) Address 1902 Eutaw Place.

19 MAY 2 - 1944 (b) Harry Williams, M.D.
(Registered by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 30th. 1944, at 8.31 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 27 1944 to Apr. 30 1944 and that I last saw h alive on Apr. 30 1944.

Immediate cause of death: Cardiac dilatation — Duration 2 D 2 hrs.
Due to: Arteriosclerosis
Due to:
Other Conditions: Cerebral hemorrhage
(Include pregnancy within 3 months of death)
Major findings: Of operations None
Of autopsy None

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Sister S. Levy, M.D.
Address 2322 Eutaw Place. Date signed 5/1/44

VS 3

16784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16784
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 Newburn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Newburn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William N. Purdy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Purdy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 | 26 | 1882

8. AGE: Years	Months	Days	If less than one day
61	6	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Hygiene
11. Industry or business School Hygiene

FATHER
12. Name Leo R. Purdy
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Margaret V. Whitbeck
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs Elizabeth Purdy
(b) Address 409 Newburn Ave.

17 (a) Burial (b) Date thereof 5-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Maryland

18 (a) Funeral director Loring Byrd
(b) Address 5 Park Heights Ave

19 MAY 2 - 1944 (Date rec'd by registrar) Hattie M. Williams M.D. Registrar

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944 at 10:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to April 30 1944, and that I last saw him alive on 4/29 1944

Immediate cause of death Coronary heart disease — Duration 4 years

Due to Arteriosclerotic heart disease — Duration 4 years

Due to — Duration —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Harry Lee Hamilton M. D.
Address 201 E. Preston St Date signed 4/30/44

16785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16785
Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5924 Bellona Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5924 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel J Monroe (MUNROE)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edwards K. Monroe
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1873

8. AGE: Years 71 | Months — | Days 19 | If less than one day ... hr. — ... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housemaker
11. Industry or business

FATHER 12. Name Charles M. Jessop
13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Emma M. Booth
15. Birthplace Balto. Co. Md.

16 (a) Informant C. Walter Jessop
(b) Address Glen Arm, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto., Md.

18 (a) Funeral director Lemmon M. Brooks
(b) Address Govans, Md.

(Date rec'd by Registrar) MAY 2 — 1944 (b) Registrar Hunting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 1944, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1940 to April 23 1944, and that I last saw h[illegible] alive on April 23 1944

Immediate cause of death: Coronary occlusion — Duration: 1 hour
Due to: Arteriosclerosis — 5 years
Due to: Hypertension — 10 years
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature A. A. Chalfant
Address 6210 York Rd. Date signed May 1st 1944 M. D.

16786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C 16786

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Estell Red.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Baby Red

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 42 yr. Months — Days — If less than one day hr. min.

9. Birthplace So. Car. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Fredy Gates

13. Birthplace S. C.

MOTHER 14. Maiden Name Sarah Stevens

15. Birthplace S. C.

16 (a) Informant Baby Red

(b) Address 1607 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)

(c) Cemetery or crematory St. Columba

Location St. Stephens, So. Car.

18 (a) Funeral director Chas. B. Alexander

(b) Address 927 N. Mount st

MAY 2 - 1944 (Date rec'd by Registrar) Huntington Williams Mgr. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1944 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1944 to 4/30 1944 and that I last saw h alive on 4-30 1940.

Immediate cause of death Lobar Pneumonia — Duration 5 d

Due to — Duration 2 w

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Fletcher M.D.

Address 1725 Eutaw Date signed 5/2/44

16787
AB-87698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16787
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos- 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Miles
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife John Miles
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 14-1901
8. AGE: Years 43 Months 1 Days 16 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name George Lamitra (D)
13. Birthplace Md.
MOTHER 14. Maiden Name Annie Carr
15. Birthplace Md.
16 (a) Informant Baltimore City Hospitals
(b) Address Records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.
18 (a) Funeral director George E. Ephraim
(b) Address 1624 Frederick Ave
MAY 2-1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH 4/30 1944, at 10:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944 to 4/30 1944 and that I last saw her alive on 4/30 1944.
Immediate cause of death Chronic myeloid leukemia — Duration 3 yr.
Due to
Due to
Other Conditions Severe anemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Sergeant M.D.
Address BCH Date signed 5/1

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100a

G 16788
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons
(c) Hospital or institution: St. Agnes Hospital No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Brushweilder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Theodore Brushweilder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Richard Faithful
13. Birthplace ?

MOTHER
14. Maiden Name De Silver
15. Birthplace ?

16 (a) Informant Mrs. Gertrude M. Brushweilder
(b) Address 241 S. Hilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leo P. Schwartz
(b) Address 2101 Eutaw Place

19 (a) (b)

MAY 2 1944

MEDICAL CERTIFICATION 28

20. DATE OF DEATH 5-1 1944, at 1-A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1944 to 5/1 1944, and that I last saw her alive on 5/1 1944.

Immediate cause of death	Duration
Heart Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/29/44
Major findings of operation: Hemorrhoids
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Raffuccini M.D.
Address Date signed 5/1/44

16789 MORAGNE

BALTIMORE CITY HEALTH DEPARTMENT 1500 Madison Ave

Registered No. 16789

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ollie Moragne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1885

8. AGE: Years 59 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Mark Jennings

13. Birthplace Georgia

MOTHER 14. Maiden Name Pitts Jennings

15. Birthplace Georgia

16 (a) Informant Wade Moragne

(b) Address 822 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)

(c) Cemetery or crematory MT Calvary

Location A. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 MAY 2 - 1944 (Date rec'd by local registrar) Herrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944 at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1943 to 4-29 1944 and that I last saw h.e.r alive on 4-28 1944

Immediate cause of death: Hypertensive cardiac renal disease — Duration: over 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Rayner Browne

Address 1 W. Madison St Date signed 5/1/44

Rayner Browne.

G 16790 — BALTIMORE CITY HEALTH DEPARTMENT — G 16790 Registered No.

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Calvinton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Calvinton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Magdalen of Sacred Heart (Mary T. Davis)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1st-1900

8. AGE: Years 44 | Months 2 | Days 1 | If less than one day: hr. min.

9. Birthplace Boston (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name William Henry Davis
13. Birthplace Va

MOTHER
14. Maiden Name Emma Cully
15. Birthplace Va

16 (a) Informant House of the Good Shepherd
(b) Address 301 Calvinton Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4-1944 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetery
Location Baltimore Md.

18 (a) Funeral director George L. Depner
(b) Address 2101 Frederick Ave

19 (a) [illegible] Registrar Huntington Williams M.D. Registrar

MAY 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 25 1944, to May 2 1944, and that I last saw h[illegible] alive on May 2 1944.

Immediate cause of death: Chronic Epilepsy — Duration: years

Due to: Uberal Pneumonia — Duration: 7 days

Due to: acute Carbon dioxide intoxication — Duration: 24 hr

Other Conditions: Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T Mears M. D.
Address 804 Cathedral St Date signed 5/2/44

Write the causes of death clearly and legibly. Physicians: please write. Exact age is especially important.

16791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16791
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 N. Carolina St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1898

8. AGE: Years	Months	Days	If less than one day
46		1	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business Darford Cleaners

FATHER
12. Name Patrick Chandler
13. Birthplace

MOTHER
14. Maiden Name Cythria
15. Birthplace

16 (a) Informant Eva Chandler
(b) Address 1812 N. Carolina St.

17 (a) Removal (b) Date thereof 5/2/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Athens.
Location W. Virginia

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) MAY 2 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at 3.15 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Injured Myocardium

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed May 2, 1944

6792 Mulligan Phila Co

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16792
Registered No.

Ya

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Long Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Arlington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, ~~1875~~ 1884

8. AGE: Years	Months	Days	If less than one day
59 ~~55~~	9	24	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Hezekiah Dalk
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Jane Cooper
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address — (RECORDS)

17 (a) Removal (b) Date thereof 5/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Phila Pa.
Location Sec. 89 Lot 20

18 (a) Funeral director Wm Cook Jos
(b) Address 1917 St Paul St

MAY 2 - 1944
(Date rec'd by registrar) Hartley H. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1944, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1944, to 4/25 1944, and that I last saw h[illegible] alive on 4/25 1944

Immediate cause of death	Duration
Prob. pul. embolism or freight car. thrombosis	25 min.
Due to Post ceremony 2 post. infarction on 4/23/44	
Due to	
Other Conditions Hyperthyroidism HCVD. 2 mild failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Seymour M.D.
Address BCH Date signed 4/29

(over)

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

6793

JL - 87643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C 16793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: altimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Chavis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Luther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1890

8. AGE: Years	Months	Days	If less than one day
53	6	14	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Marion Green
13. Birthplace Va.

MOTHER
14. Maiden Name Louise Robertson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Saluta
Location Virginia

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

MAY 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1944 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1944 to 4/29 1944. and that I last saw her alive on 4/29 1944.

Immediate cause of death Cardiac decompensation; uremia

Duration 1 mo.

Due to HTN

Due to

Other Conditions Marked obesity (220 lb.)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac enlarged; As above and stone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.
Address BCH Date signed 5/1

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148 B

G 16794 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3717 DELVERNE RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 DELVERNE RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WALLETTA COGGINS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: EDWARD R. COGGINS JR.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JUNE 29 1889

8. AGE: Years 54 | Months 10 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace: FREDERICK MD. (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: ELMER KEEFER
13. Birthplace: MD.

MOTHER
14. Maiden Name: VALLETTA J. MANTZ
15. Birthplace: MD.

16 (a) Informant: EDWARD R. COGGINS JR. (HUS)
(b) Address: 3717 DELVERNE RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 3/44 (month) (day) (year)
(c) Cemetery or crematory: DRUID RIDGE
Location: PIKESVILLE MD.

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST.

18 (a) ... (b) ... (Date rec'd by registrar) ... Registrar

MAY 2 1944 Hunter Williams, M.D.

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH: MAY 1 1944 at 10/30

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1943 to 5/1 1944, and that I last saw h[illegible] alive on 4/29 1944

Immediate cause of death: Carcinoma of uterus — Duration: 2 yrs.
Due to: o Metastasis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: 12/3/43.
Major findings of operation: Carcinoma of uterus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert S. Sikinsky M. D.
Address: 5939 Dr. Ridge Dr. Date signed: 5/7/44

correct age is especially important. Physicians: please write the

G 16795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3638 ROBERT PLACE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3638 ROBERT PLACE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH C. HORNEY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:
4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MARGARET HORNEY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JULY 24 1881
8. AGE: Years 62 | Months 9 | Days 8 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name WILLIAM HORNEY
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARY BEHNER
15. Birthplace BALTO. MD.

16 (a) Informant MARGARET HORNEY (WIFE)
(b) Address 3638 ROBERT PLACE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY-5-44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

MAY 2 - 1944 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 2 1944, at 2 AM. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1944, to 5/2 1944, and that I last saw h.i.m alive on 5/2 1944.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis Chronic Lead Poisoning	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. F. LOM
Address 3215 Eutaw Pl. M.D. Date signed 5/2/44

Chas. FLOM

Dr 16796 Brown

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16796 Registered No. 13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 S. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 14 c

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 40 S. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1881

8. AGE: Years 63 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name Caroline Haywood
15. Birthplace Md.

16 (a) Informant Henrietta Wriver
(b) Address 40 S. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury Ave
(c) 5-1-1944 (By registrar) Hunting & Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28-44 19 , at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1943 to 4-28 1944
and that I last saw him alive on 4-25 1944

Immediate cause of death: Hypertensive cardiovascular disease — Duration unk.

Due to

Due to

Other Conditions arterio-sclerosis chronic myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Layner Browne M.D.
Address 1130 E. Madison St Date signed 5/1

16797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 16797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts.
(c) Hospital or institution: West Balto. Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Middle River
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 12 - Box 388 A
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM T. INGRAM

3 (b) If veteran, name war: NO.

3 (c) Social Security Account No. 21-610-7744

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Mary Ingram

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 4/22/1882

8. AGE: Years 62 | Months - | Days 11.9 | If less than one day: hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Mill Wright

11. Industry or business

FATHER
12. Name Hugh Ingram
13. Birthplace West Virginia

MOTHER
14. Maiden Name unknown
15. Birthplace West Virginia

16 (a) Informant Jay Ingram
(b) Address Bragg Point

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 6 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Akron Ohio.

18 (a) Funeral director Wendell Hoppel
(b) Address 312 S. Highland Ave

MAY 3 - 1944
(Date rec'd by registrar) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1944 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25/1944 to 5/1 1944 and that I last saw him alive on 5/1 1944

Immediate cause of death: Bronchopneumonia
Cardiac Failure — Duration

Due to

Due to

Other Conditions Arteriosclerosis CVD
Cardiac Failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. N. Friedman

Address West Balt Genl Hosp Date signed 5/1/44 (M D)

VS 150

Write the causes of death clearly and legibly. Physicians: please write correct age in completely filled spaces.

16798

AB-54935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 12B

C 16798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs- 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Benhill Ave-Curtis Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Zwarick or Stif Zwarik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known ?

8. AGE: Years 60 ? Months Days If less than one day hr. min.

9. Birthplace Russie
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Zwarick
13. Birthplace Russia

MOTHER
14. Maiden Name Urina ?
15. Birthplace Russia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3- 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run B.C. County

18 (a) Funeral director John A. Grebiangelo Jr.
(b) Address 423 S. Paca St

19 MAY 3- 1944 (Date rec'd by registrar) (b) Huntley W. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1- 1944, at 10 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/1 1944.
and that I last saw h[illegible] alive on 5/1 1944.

Immediate cause of death Pulmonary TBC — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Lugman M. D.

Address BCH Date signed 5-1-

correct age is especially important. A physician, please write plainly.

16799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution: Union Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 St Paul St
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Holden Winfield Anderson

3 (b) If veteran, name war: none

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lydia A. Anderson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 7 1868

8. AGE: Years 76 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual Occupation retired -

11. Industry or business (Boiler)

FATHER
12. Name Ezekial Anderson
13. Birthplace Kent Co. Md

MOTHER
14. Maiden Name Susanne Roberts -
15. Birthplace Kent Co. Md.

16 (a) Informant Mrs. Mildred A. Herr (daughter)
(b) Address Philadelphia Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 44 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Massey - Kent Co. Md.

18 (a) Funeral director Sullivan Mowell Co.
(b) Address 108 W. Mulberry St.

19 (a) MAY 3 - 1944 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1944 to May 2 1944 and that I last saw him alive on May 2 1944.

Immediate cause of death: Lobar Pneumonia (Rt.) — Duration: 4 Days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Garrison M.D.
Address 1401 Garrison Blvd Date signed May 1 1944

CORRECT COPY OF THE ORIGINAL RECORD

VS 250

16800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G 16800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Agnes Teresa Carroll

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife none.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Aug. 20, 1867~~ ~~June 20, 1867~~

8. AGE: Years 76 ~~77~~ Months 8 Days 10 If less than one day hr. min.

9. Birthplace Maryland. (Balto. City)
(Town, county, and state)

10. Usual Occupation retired teacher.

11. Industry or business Public School - Balto. City

FATHER
12. Name Thomas C. Carroll.
13. Birthplace Md. IRELAND

MOTHER
14. Maiden Name Margaret Ellen Green.
15. Birthplace Balto. Md.

16 (a) Informant Sister C. J. Hennick (nephew)
(b) Address 607 McElderry Ave.

17 (a) London Park (Burial, cremation, or removal) (b) Date thereof May-3-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 1 of W. Lanvale St.

19 (a) MAY 3 - 1944 (Date rec'd by registrar) Hampton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1944, at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1944 to 4/30 1944, and that I last saw her alive on 4/30 1944.

	Duration
Immediate cause of death Cardiac failure.	
Due to congestive cardiac failure.-	8 days
Due to arteriosclerotic heart disease.-	
Other Conditions myocardial ischemia + pulmonary edema. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chiffelle M. D.
Address Union Memorial Hospital Signed 4/30/44.

PHYSICIAN
Underline the cause to which death should be charged statistically.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 350

G 16801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1005 N. Charles St.
(b) Street address 3rd--Park Ave
(c) Hospital or institution:
(at the home of his daughter)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. XXXXXXXXXXXXXXX 313-E.-29th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (CHRIS) CHIN QUON (CHIN QUON)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: Chinese | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of XXXXXXX wife Batty Chin Quon
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Chinese Calender

8. AGE: Years 68 | Months - | Days - | If less than one day hr. min.

9. Birthplace China
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Importing

FATHER
12. Name Chin Tai
13. Birthplace China

MOTHER
14. Maiden Name Der Shee
15. Birthplace China

16 (a) Informant Mr. Wroth Chin (Son)
(b) Address 313 E. 29th. St., City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 E. North Av. (W. F. Wooden-Suc.)

19 (a) MAY 3 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at 12 15 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 5-3-44

16802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G-16802

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Liberty P'way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Barnett BARNETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Esther nee Pudam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 Months Days If less than one day hr. min:

9. Birthplace (Town, county, and state) Russia

10. Usual Occupation Pharmacist Merchant

11. Industry or business

FATHER
12. Name Philip Barnett
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael -
15. Birthplace Russia

16 (a) Informant Esther Barnett
(b) Address 8 Liberty P'way, Dundalk, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jos Levin Inc
(b) Address 1439 E. Balto St.

MAY 3 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1944 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1944 to 5/1 1944, and that I last saw him alive on 4/30 1944.

Immediate cause of death Pulmonary embolism - multiple. Branchogenic carcinoma

Due to Hypostatic congestion

Due to decomposition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Stanley M.D.
Address Sinai Hospital Date signed 5/1/44

VS 150

16803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

✓ G 16803 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4833 Reis. Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4833 ~~Reis~~ Registration Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Eisenstadt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ely Eisenstadt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name Landy Forman
13. Birthplace Russia
MOTHER: 14. Maiden Name Lena –
15. Birthplace Russia

16 (a) Informant Ely Eisenstadt
(b) Address 4833 Reis. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Northern Ave
Location Shaarai Tefila Cong

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St

19 (a) MAY 2 – 1944 (Date received by registrar) Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2-44 19 .. at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1944, to 5/2 1944, and that I last saw h alive on 5/2 1944.

	Duration
Immediate cause of death: Pulmonary edema	1 day
Due to Sarcoma metastasis general	4 mos
Due to Sarcoma of uterus	1½ yrs?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 1943
Major findings of operation: Sarcoma of the uterus
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack Levinson
Address 4004 Liberty Hgts Ave Date signed 5/2/44

16804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16804

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 N. Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Fremont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Louise Curry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Preston Curry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 54 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name Wm H. Heel
13. Birthplace N. C.

MOTHER
14. Maiden Name Maggie Taylor
15. Birthplace Md

16 (a) Informant Martha A. Jackson
(b) Address 318 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Saratoga St

MAY 3 - 1944 (Date rec'd by local registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at 6.55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 28 1944 to May 2 1944, and that I last saw her alive on May 1 1944

Immediate cause of death Acute Lobar Pneumonia — Duration 7 Dys

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dunbar Vernon M. D.

Address 1111 Linden Ave Date signed 5/2/44

G 16805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. G 16805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 WALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 WALL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT. P. WAGNER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-7356

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife LILLIAN. M. WAGNER

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) JUNE 6- 1879

8. AGE: Years	Months	Days	If less than one day
64	10	26	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation MACHINIST & DYE MAKER

11. Industry or business

FATHER 12. Name ADOLPH. WAGNER

13. Birthplace GERMANY.

MOTHER 14. Maiden Name GENEVIEVE MARTIN

15. Birthplace NOT KNOWN

16 (a) Informant LILLIAN M. WAGNER

(b) Address 1238 WALL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-6-44 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A.A. Co.

18 (a) Funeral director Bernard C Horle

(b) Address 121 E West St.

MAY 3- 1944 (Date rec'd by registrar) Hunter Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 2nd 1944 at 1.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 5/2 1944 and that I last saw h alive on 19

Immediate cause of death: Carcinoma of rectum — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.

Address 20 E Wilkens Ave Date signed 5/2/44

HARRELL

16806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G 16806
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... University Hosp. at
(c) Hospital or institution:
Redwood and Greene Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Paca St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Noah Harrell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Harrell
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 8, 1905

8. AGE: Years 39 | Months - | Days 22 23 | If less than one day ... hr. ... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Harrell
13. Birthplace N. C.

MOTHER
14. Maiden Name Deci
15. Birthplace N. C.

16 (a) Informant Mary Harrell (Wife)
(b) Address 605 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-1944 (month) (day) (year)
(c) Cemetery or crematory Oulander Baptist Cemetery
Location Oulander N. C.

18 (a) Funeral director Charles B. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) ... (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

MAY 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1944, at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1944, to May 1 1944, and that I last saw h... alive on 5/1 1944.

Immediate cause of death	Duration
Hem. Thorax	
Due to Ruptured Aneurysm	
Due to Erosion of Arch of Aorta into lung	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Erosion of Aorta into Lung.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin H. Hemmeter, M. D.
Address Univ. Hosp. Date signed 5/1/44

G 16807 ✓ to Woodland

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Use a typewriter if possible. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 942 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 942 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Georgia
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-15-1889

8. AGE: Years	Months	Days	If less than one day
54	4	15	hr. min.

9. Birthplace Charlottesville. Va
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business B & O. R.R.

FATHER
12. Name Harry Williams
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Georgia Williams
(b) Address 942 Harlem ave
17 (a) Burial (b) Date thereof 5-5-44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location G. C. County Md
18 (a) Funeral director William Jackson
(b) Address 916 Pennsylvania ave
19 (a) (Date Rec'd) MAY 8 1944 (Registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at 12 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 25 1944, to Apr. 30 1944, and that I last saw h[illegible] alive on April 30, 1944.

Immediate cause of death	Duration
Coronary Heart Disease	???
Due to Arterio-sclerosis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles Wardell M.D.
Address 861 Harlem Date signed 5/2/44

16808 — BALTIMORE CITY HEALTH DEPARTMENT — G 16808

CERTIFICATE OF DEATH

91a — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 670 W. Saratoga
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Adolph Howard

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Martha Howard
6 (c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): 3-12-1912
8. AGE: Years: 32 | Months: 1 | Days: 18 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business: —

FATHER
12. Name: Lindsay Howard
13. Birthplace: Md

MOTHER
14. Maiden Name: Julia Goode
15. Birthplace: Va

16 (a) Informant: Julia Howard
(b) Address: 635 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5 (month) 9 (day) 44 (year)
(c) Cemetery or crematory: Mt. Calvary Cem
Location: Baltimore Co. Md

18 (a) Funeral director: Williams & Jackson
(b) Address: 916 Penbroke ave

19 Date received by registrar: MAY 3 - 1944 — Huntington Williams M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Examine the certificate and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1944, at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1944, to April 30 1944, and that I last saw him alive on April 30 1944.

Immediate cause of death	Duration
Lobular Pneumonia	
Due to: Hypostatic condition of patient	
Due to:	
Other Conditions: Pachymeningitis Interna, Subacute Bact. Endocarditis	

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation: —
of autopsy: 4-30-44

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Alvin N. Hongaran M. D.
Address: Univ. Hospital
Date signed: 4/30/44

G 16809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 16809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Potter

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife ARCHER E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4, 1874

8. AGE: Years 70 | Months 0 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name JOSEPH LANKFORD
13. Birthplace MD

MOTHER 14. Maiden Name ELIZABETH MADDOX
15. Birthplace MD.

16 (a) Informant MISS MILDRED POTTER
(b) Address 2106 CHELSEA TERR.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEM.
Location WOODLAWN, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

MAY 2 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 1944, at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. Mahoney Medical Examiner.
Date signed 4/30/44

G 16810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 16810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 5/1/44-3:00 P.M.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.8 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4241 Wickford Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES A. WICKLIFFE

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary McPherson
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.): 10/28/1884

8. AGE: Years 59 | Months 6 | Days 4 3 | If less than one day ... hr. ... min.

9. Birthplace: Louisiana (Town, county, and state)
10. Usual Occupation: Col. (USA)
11. Industry or business: U.S.Army

FATHER
12. Name: John C. Wickliffe
13. Birthplace: Bardstown, Ka.

MOTHER
14. Maiden Name: Sally Mattingly
15. Birthplace: Bardstow, Ka.

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory: National Cem.
Location: Arlington, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAY 3 - 1944 [illegible] Williams M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1944, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1944 to May 1, 1944, and that I last saw him alive on May 1, 1944.

Immediate cause of death: 1. Marked coronary sclerosis with complete occlusion of the ant. descending branch of the left coronary artery and the main rt. coronary artery. 2. Myocardial degeneration & fibrosis (due to No. 1) — Duration: Unk.

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: L.O.S. Brown M.D.
Address: Baltimore, Md. Date signed 5/2/44

VS 150

USA-52727

16811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16811
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Ho.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID LAUGHLIN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Augusta Harrison Laughlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 9/6/1856

8. AGE: Years: 87 | Months: 7 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired Clergyman
11. Industry or business

FATHER:
12. Name: James Laughlin
13. Birthplace: Ireland

MOTHER:
14. Maiden Name: Mary Gibb
15. Birthplace: Ireland

16 (a) Informant: Mr. James F. Laughlin, Nephew
(b) Address: 2828 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAY 3 1944

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1944, at 8:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to May 1 1944; that I last saw him alive on May 1 1944.

Immediate cause of death: Hypertension Cerebral Hemorrhage — Duration: 5 d

Due to:

Due to:

Other Conditions: Prostatism

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Fritz J. Shinzer M. D.
Address: 2700 Harford Road Date signed May 2 1944

VS 160

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139B

Registered No. G 16812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Josephs Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Voelker

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Ernest Voelker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/1859

8. AGE: Years	Months	Days	If less than one day
85	1	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Nurse - Housewife
11. Industry or business —

FATHER
12. Name Christian Collenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Deiter
15. Birthplace Germany

16 (a) Informant Mrs. Anne V. Balster
(b) Address 3908 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 3 - 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 19 44, at 3 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 19 44, to 5/2 19 44, and that I last saw her alive on 5/2 19 44.

Immediate cause of death Respiratory failure — Duration

Due to Hypostatic Pneumonia

Due to Cardiac Failure

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation 4/1/44
Major findings of operation: Third degree prolapse of uterus
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place).
(e) Means of injury —

23. Signature Melvin L. Janowski M.D.
Address St Josephs Hosp Date signed 5/2/44

VS 150

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

6813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93P

G 16813
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/14/1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1/14/1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Caroline
(c) City or town Denton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT PAUL CRAFT

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nora Baker
6 (c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.) 7/5/1895
8. AGE: Years 48 | Months 9 | Days 27 | If less than one day ... hr. ... min.
9. Birthplace Williamsburg, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Phillips Canning Co.

FATHER
12. Name Wm. H. Craft
13. Birthplace Mardella Springs, Md.

MOTHER
14. Maiden Name Edna Woolen
15. Birthplace Oakgrove, Md.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Denton
Location Denton, Md.

18 (a) Funeral director Virgil Moore
(b) Address Denton, Md.

(Date rec'd) MAY 3 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH May 2, 1944, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1944 to May 2, 1944, and that I last saw h. im alive on May 2, 1944

Immediate cause of death: Hypertensive cardiovascular disease with uremia — Duration: Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm M Crawford M. D.
Address Baltimore, Md. Date signed 5/2/44

Va-14242 WM. M. CRAWFORD, M.D.

6814 BALTIMORE CITY HEALTH DEPARTMENT G 16814

CERTIFICATE OF DEATH

54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charlestown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Bush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1919

8. AGE: Years 25 | Months - | Days 12 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Brown Bush

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Bush

15. Birthplace Va.

16 (a) Informant Grover L. Bush

(b) Address Charlestown W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7/44 (month) (day) (year)

(c) Cemetery or crematory Edge Hill Cemetery

Location Charlestown W. Va

18 (a) Funeral director Harry H. Witzke

(b) Address Kabl Edmondson Asst.

19 (a) MAY 3 - 1944 (Date rec'd by Registrar) Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1944; at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944, to 5/2 1944 and that I last saw h.... alive on 5/2 1944.

Immediate cause of death	Duration
Respiratory failure	5 hrs.
Due to Cerebellar tumor	5+ yrs.
Due to	
Other Conditions (Include pregnancy within 3 months of death)	over

Date of operation 5/2/44

Major findings of operation: None.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin M. D.

Address University Hospital Date signed 5/2/44

VS 100

8815 SIZEMORE ✓ G 16815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2141 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel ~~Albert~~ Sizemore Albus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jos C Albus

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1912

8. AGE: Years 31 | Months 7 | Days 20 | If less than one day: hr. min.

9. Birthplace Middleburg Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Emmet Hinckley
13. Birthplace Flint Hill Va

MOTHER
14. Maiden Name Ella Coplin
15. Birthplace Flint Hill Va

16 (a) Informant Jos C Albus
(b) Address 2141 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Jno F Kenny
(b) Address Holland & Gilmartin, Williamsport Md

MAY 3 - 1944 (Date rec'd by Registrar)

VS 150

correct age in especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1944 to 5/1 1944 and that I last saw h alive on 5/1 1944.

Immediate cause of death Acute Pancreatitis & Shock — Duration

Due to Same

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute Pancreatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rachel Baldwin M. D.
Address WB.G.H Date signed 5/1/44

16816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 16816

Registered No. 1276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. Balto. St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Robert Parsons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 - 1868

8. AGE: Years	Months	Days	If less than one day
75 74	7	17	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER
12. Name John
13. Birthplace Md

MOTHER
14. Maiden Name Matilda Watts
15. Birthplace Md

16 (a) Informant Mrs. Frank Faulson
(b) Address 2025 W Balto St

17 (a) Burial (b) Date thereof 5/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Lawn
Location Lynch Kent Co Md

18 (a) Funeral director Edward Faulson
(b) Address 2359 West Biltd

MAY 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1944 to 4/29 1944 and that I last saw h.e alive on 4/29 1944

Immediate cause of death ~~Coronary Thrombosis~~
Ruptured Gall Bladder
Generalized Peritonitis
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Same

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Kirby M. D.
Address Franklin Sq. Hosp Date signed 4/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

G 16817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G 16817

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fountain & Green

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 3 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 216 St Paul St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie C. Jenkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or divorced~~
F	W	Widow

6 (b) Name of husband or wife Michael Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name John Coyne
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Daugly
15. Birthplace Ireland

16 (a) Informant Hosp. records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location Harford Road & Annapolis Ave

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 Filed MAY 3 1944 (b) Registrar Williams M.D.

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1944 to 5-2 1944 and that I last saw h~~e~~r alive on 5-2 1944

Immediate cause of death	Duration
Pneumonia	
Type 6	
Due to	
Due to	
Other Conditions Septicemia	
type 6 pneu. Pul-edema.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank M. Shipley M. D.

Address University H Date signed 5-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6818

G 16818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution McKenna Memorial Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bradford Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Harry H. Roy

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Mollie Frederick
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1863

8. AGE: Years 81 | Months 2 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Fruit Broker
11. Industry or business .....

FATHER
12. Name John Roy
13. Birthplace Baltimore

MOTHER
14. Maiden Name Adelaide Hall
15. Birthplace Baltimore, Md.

16 (a) Informant Robert H. Roy
(b) Address Ruxton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Date received by Local Registrar MAY 3 1944 (b) Houghton Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 30 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to April 30 1944 and that I last saw h alive on April 30, 1944

Immediate cause of death Carcinoma of Gland of neck
Due to & throat
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation .....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature John H. Evans M. D.
Address 612 W. 40th St. Date signed May 1 1944

16819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

G 16819

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 H

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Queenies

(c) City or town Sharptown Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Eleanor Cordrey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/17 1917

8. AGE: Years 27 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER

12. Name ARTHUR —

13. Birthplace Delaware

MOTHER

14. Maiden Name Winnie Henry

15. Birthplace Delaware

16 (a) Informant Minnie Cordrey

(b) Address Sharptown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5-1944 (month) (day) (year)

(c) Cemetery or crematory Friendship

Location Sharptown Md.

18 (a) Funeral director Graveyard Bros

(b) Address Sharptown

19 (a) Date received by Local Registrar MAY 3 1944 (b) Signature Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1944, to 5/2 1944, and that I last saw her alive on 5/2 1944.

Immediate cause of death Shock

Respiratory failure

Duration

Due to Severe Bronchiectasis.

Due to L. pneumonectomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/27/44

Major findings of operation: Bronchiectasis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. L. Gillespie M. D.

Address Mercy Hosp Date signed 5/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16820 Registered No. 115c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 Y Belair Rd
(c) Hospital or institution: 25th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 3134 Thornton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert B. Eyl.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-23-1935

8. AGE: Years	Months	Days	If less than one day
8	10	9	hr. min.

9. Birthplace Plymouth Pa. (Town, county and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Robert J. Eyl.
13. Birthplace W. Va.

MOTHER 14. Maiden Name Grace M. Hamer
15. Birthplace Pa

16 (a) Informant Robert J. Eyl
(b) Address 3134 Thornton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)
(c) Cemetery or crematory
Location Bergwick Pa.

18 (a) Funeral director Luff Rusk
(b) Address 5302 Harford Rd.

19 (a) MAY 3 - 1944 Huntington Williams Mortuary

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29 1944, to 5-7 1944, and that I last saw h alive on 5-7 1944.

Immediate cause of death Cerebral Embolism

Due to

Due to Sarcoidosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-4-44

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of inj

23. Signature Michael Krantz M. D.
Address 540 Y Belair Rd Date signed 5-7-44

W. L. Wollenweber M.D. Asst Medical Examiner

16821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 16821
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1133 N. Gilmor Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 N. Gilmor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME James Cherry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1944

8. AGE: Years | Months | Days 2d | If less than one day hr. min.

9. Birthplace Dalton, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Cherry
13. Birthplace S.C.

MOTHER
14. Maiden Name Annie Lee
15. Birthplace N.C.

16 (a) Informant James Cherry
(b) Address 1133 N. Gilmor St.

17 (a) (Burial, cremation, or removal) (b) Date thereof May 3-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Geo. E. Edelen
(b) Address 1355 Pressman St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944, at 6:30 A. M

21. I certify that I took charge of the remains described above, held an ..... Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia Lobular

Due to Prematurity

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeier M.D.
Medical Examiner.
Date signed May 3, 1944.

VS 151

PRINT NAME PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. D. A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Bricker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa Bricker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Rosa Bricker
(b) Address 5 S. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradley Ave

19 (a) MAY 3 1944 (Registrar's signature) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 8:12 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Grant Le Fontaine M.D. Medical Examiner.
Date signed May 2, 1944

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

16823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 16823
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 E Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie B. Wackerhauser

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John G. Wackerhauser 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1874

8. AGE: Years	Months	Days	If less than one day
69	11	2	hr. min.

9. Birthplace Balto. City Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Chas Wille
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Stoll
15. Birthplace Germany

16 (a) Informant Mrs. Gleonard Rye
(b) Address Glenarm Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 4 (day) 44 (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 1944 Belair Rd.

19 (a) MAY 3 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 2 1944 and that I last saw her alive on May 2 1944

Immediate cause of death	Duration
Cardiac Dilatation	1 day
Due to Myocardial Insufficiency and	
Due to Generalized Arteriosclerosis	1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M.D.
Address 3015 Eutaw Pl. Date signed 5/2/44

VS 150

G 1634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 16824 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5702 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Schuchardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16.55

8. AGE: Years	Months	Days	If less than one day
88	3	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Wills
13. Birthplace Germany

MOTHER
14. Maiden Name Kraff
15. Birthplace Germany

16 (a) Informant Mrs. Anna Trotter
(b) Address 3008 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Maryland

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) May 2nd 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1934 to 19
and that I last saw h alive on April 27 19 44

Immediate cause of death Myo. Carditis

Due to General debility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2824 St. Paul St. Date signed May 1-44

G 16825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G 16825 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3428 Elm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore ? (If outside city or town limits, write RURAL and give town)
(d) Street No. 3428 Elm Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

13 6

3 (a) FULL NAME Thomas R Wann
3 (b) If veteran, name war —
3 (c) Social Security Account No. 219-12-5188
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Catherine O. WANN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr 3-1868
8. AGE: Years 76 Months — Days 29 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Balto City Fire Dept
FATHER 12. Name Daniel A Hann
13. Birthplace Md
MOTHER 14. Maiden Name Elizabeth A Hecker
15. Birthplace Md
16 (a) Informant Mrs Myrtle Clagett
(b) Address 3428 Elm Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Cemetery
Location Taylor Ave Baltimore Md
18 (a) Funeral director Frank H Seitz
(b) Address 814 W 36 St
19 (a) (Date rec'd by reg.) (b) Interment, Huntingtown, Md.

MAY 3-1944
MAY 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1944, 9:10 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12th 1944 to May 2nd 1944 and that I last saw him alive on May 2nd 1944

	Duration
Immediate cause of death Carcinoma of Bladder	6 mo
Due to None	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. A. Lillick M. D.
Address 311 Fallsway Date signed 5/2/44

G 16826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1382

G 16826 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 / 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Welbourne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Walter Welbourne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-19

8. AGE: Years: 24 | Months: 10 | Days: 23 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation house wife

11. Industry or business

MOTHER / FATHER

12. Name James Tillman

13. Birthplace Md

14. Maiden Name Mary Wright

15. Birthplace Md

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Mrs Kate R Williams

(b) Address 3227 N Schroeder St

Huntington Williams Mgr

MAY 8 - 1944

(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944 at 6.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to April 30 1944, and that I last saw ~~her~~ alive on April 30 19 44

Immediate cause of death ~~Hypertension~~ Respiratory failure — Duration

Due to Tuberculous pleurisy pericarditis

Due to and pneumothorax

Other Conditions Cardiac insufficiency Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22, If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John H Cunningham M. D.

Address JHH Date signed 4/30

~~16827~~ G 16827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170c

Registered No. 1

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Warner st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anne D. Gibbs Shields

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 19, 1942

8. AGE: Years 2 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and State)

10. Usual Occupation none child

11. Industry or business

FATHER 12. Name Paul Shield

13. Birthplace Richmond Va

MOTHER 14. Maiden Name Evelyn Gibbs

15. Birthplace Washington D C

16 (a) Informant Evelyn Gibbs Shield

(b) Address 700 Warner st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore city

18 (a) Funeral director Joseph A Lively

(b) Address 409 N Mount street

19 (a) MAY 3 - 1944 (Date received by Registrar) (b) Hunter's or Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 5:30 P

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury May 1st 1944 22-2 M.

(b) Where did injury occur? Warner St near Home

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No

(d) Means of injury Struck by auto skunk

23. Signature Roland Lee Frazier M.D. Medical Examiner.

Date signed May 2, 1944

16828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16828

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. ~~244~~ 202 N. ~~Exeter St.~~ High St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rosa Genco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph Genco

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-1877

8. AGE: Years	Months	Days	If less than one day
67?	2	21	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Frank ~~Pipitone~~ Pisotri

13. Birthplace Italy

MOTHER

14. Maiden Name Jacqueline Pipitone

15. Birthplace Italy

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Frank V. Pipitone

(b) Address 218 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 8 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1944 at 9:40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1944, to 5-2 1944, and that I last saw h[illegible]live on 5-2 1944.

Immediate cause of death: Bronchopneumonia

Due to: Urinary Retention

Due to: Arteriosclerotic Cardiovascular Disease

Other Conditions

Duration: 3 da / ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald Bolett

Address Balt City Hosp Date signed 5-8-44

G 16829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd 1902

8. AGE: Years 42 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace Louisanna (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Dennis J Woods
13. Birthplace Nevada

MOTHER
14. Maiden Name Angeline Malcolm
15. Birthplace Louisanna

16 (a) Informant Mr Hawkins
(b) Address 1134 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5th 1944 (month) (day) (year)
(c) Cemetery or crematory Beaumont Cemetery
Location Beaumont Texas

18 (a) Funeral director Leo G. Legoute
(b) Address 1701-23 N Patterson Park Ave

19 MAY 3 - 1944 Where recorded by registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Williamson M.D.
Medical Examiner.
Date signed May 3, 1944.

VS 151

Physicians: please write the causes of death clearly and legibly. Important. Physicians: please write the correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 16830

C16830 ✓ 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Forest, Park
(c) Hospital or institution: U nursing Hosp. 4-1-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 dys
(e) Length of stay in Baltimore (yrs., mos., or days) ?.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town West minster.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Leo Mumford.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ethel Mumford
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) ? June 26, 1900

8. AGE: Years	Months	Days	If less than one day
43	10 ?	6	..... hr. ..... min.

9. Birthplace ? Md.
(Town, county, and state)
10. Usual Occupation Shoe Cutter
11. Industry or business

FATHER
12. Name George Mumford
13. Birthplace Md.

MOTHER
14. Maiden Name Emmie Eyler.
15. Birthplace Md.

16 (a) Informant Ethel Mumford.
(b) Address Westminster Md.

17 (a) Burial (b) Date thereof May 6. 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) ..... (b) Huntington Willis, Registrar
(Date rec'd by registrar)

MAY 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2/ 1944; at 11.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1944, to 5/2 1944, and that I last saw him alive on 5/2 1944.

Immediate cause of death ..... pulmonary hemorrhage
Resp. failure
Due to Old T.B. pulmonary.
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Chas Routh M.D.
M. D.
Address U nursing Hosp Date signed 5/3/44

C 16831

G 16831

G 16831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 S Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 S Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Grim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Elias M. Grim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1872

8. AGE: Years 71 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation house work.

11. Industry or business at home

FATHER
12. Name Charles W. Weaver
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Mrs Sylvia J. Pulliam
(b) Address 29 S Stricker Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 5 (day) 44 (year)
(c) Cemetery or crematory Mt Hebron
Location Winchester, Va.

18 (a) Funeral director John L. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) MAY 3 1944 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, '44 1944 at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9/43 19 to 5/1 1944, and that I last saw h.e.r alive on 5/1 1944

Immediate cause of death Calvin Carcinoma — Duration 1 yr

Due to

Due to

Other Conditions Arteriosclerosis Cardio Vascular Disease — over 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carey Rowling

Address 1316 W Lombard St Date signed 5/3/44

G 16832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gaysor + Fayette Sts
(c) Hospital or institution Bon Secour Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Late Thomas F. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1897

8. AGE: Years 46 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Henry G. Bagle
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary B Tavern
15. Birthplace West Va

16 (a) Informant Mrs. Walter R. Frederick
(b) Address 1929 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) MAY 3 - 1944 Washington Williams Registrar
(Date received by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1944 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1944 to 5/2 1944 and that I last saw her alive on 5/2 1944.

Immediate cause of death	Duration
Massive Pulmonary Embolus	
Due to Postoperative.	8 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/25/44

Major findings of operation: Fibroid Uterus + Chronic Appendix

of autopsy: Pulmonary Embolus

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Rogers M.D.
Address 1 W Lexington St Date signed 5/4/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. Use write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~13833~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G 16833
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Avenue & Druid Hill Park
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Payson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1944

8. AGE: Years	Months	Days	If less than one day
0	-	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name Rita Hartman

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 3 1944

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 3 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1944, at 6:20 P.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from 5/1 1944, to 5/1 1944, and that I last saw her alive on 5/1 1944.

Immediate cause of death	Duration
Respiratory Failure	
Dehydration, Acidosis	
Due to Diarrhea of Undetermined Etiology	3 days
Due to	
Other Conditions Possible Cerebral Hemorrhage (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Stubbs M.D.
Address University Hosp Date signed 5/1/44

0911

G 16834

G 16834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital 7 days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Reynolds St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Joyce Marie Allen

3 (b) If veteran, name war / | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/44

8. AGE: Years | Months | Days 5 days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Carl Allen
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Marie Woodland
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 3 1944 (Date Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1944 at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27- 1944, to 5-1 1944, and that I last saw h alive on 5-1 1944

Immediate cause of death Accidental Heart Disease — Duration

Due to Death — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis Hess M. D.
Address 5 W. Wilcox Rd Date signed 5/2/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

0912

G 16835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

G 16835

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton + Wilkens Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Howard.

(c) City or town Elchester

(If outside city or town limits, write RURAL and give town)

(d) Street No. 61

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Carey

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-7303

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Kelly Carey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1908

8. AGE: Years 35 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Elchester, Md. (Town, county, and state)

10. Usual Occupation Capt. of Bogota

11. Industry or business Doughnut Corp.

FATHER 12. Name H. B. Carey

13. Birthplace Elchester, Md.

MOTHER 14. Maiden Name Nellie Frederick

15. Birthplace Howard Co. Md.

16 (a) Informant Mrs Hugh B. Carey

(b) Address Elchester, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1944 (month) (day) (year)

(c) Cemetery or crematory St Mary's Cem.

Location Elchester, Md.

18 (a) Funeral director Easton Sons

(b) Address Ellicott City, Md.

19 (a) Date rec'd by Registrar MAY 3 - 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/44 19 , at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23/44 19 to 5/1/44 19 , and that I last saw deceased alive on 3/1/44 19

Immediate cause of death	Duration
Uraemia Coma	
Due to Malignant Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryan M.D.

Address St. Agnes Hosp Date signed 5/1/44

G 16836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16836 Registered No. 127B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. They correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7701 Seven Mile Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Lottie Fryfogle — Lottie E. Fryfogle

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph H. Fryfogle
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) January 16, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	16 17	hr. min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Warner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Maryland

16 (a) Informant Mr. Joseph H. Fryfogle
(b) Address 7701 Seven Mile Lane, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5,1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Reisterstown, Md.

18 (a) Funeral director C. Willis Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) Huntington Williams, M.D.

MAY 3 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944 to 5/2 1944 and that I last saw h alive on 5/2 1944

Immediate cause of death Biliary Peritonitis — Duration

Due to Ruptured Gall Bladder gangrenous

Due to impacted stone in gall bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/30/44

Major findings of operation: Gangrenous gall bladder with impacted stone

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Kemper M. D.
Address Univ. Hospital Date signed 5/3/44

G 16837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G 16837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 132 Hillard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aurelio Ronald Mannello

3 (b) If veteran, name war None

3 (c) Social Security Account No. 207-03-9858

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna Mannello

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1915

8. AGE: Years 28 Months 5 Days 8 If less than one day hr. min.

9. Birthplace Mt. Carmel Pennsylvania (Town, county, and state)

10. Usual Occupation Shipper Woolen

11. Industry or business Bethlehem Fairfield

FATHER
12. Name James Mannelo
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine Guarna
15. Birthplace Italy

16 (a) Informant Anna Mannelo
(b) Address 2402 Wilkins Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2444 Frederick Avenue

19 MAY 4 - 1944 (Date rec'd by registrar) (b) Thomas J. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944, at 6:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning Suicide

Due to Mental despondency

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-2-44 at M.
(b) Where did injury occur? at home address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Kitchen gas stove

23. Signature H. J. Wollenweber M.D. Medical Examiner.
Date signed May 3, 1944.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C 16838

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie L. Yeoman

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband: Benjamin F. Yeoman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6th 1847

8. AGE: Years	Months	Days	If less than one day
97	2	26	hr. min.

9. Birthplace Modena Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Charles W. Yeoman
(b) Address R.F.D. #13 Bx 353 Balto. 21 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/44
(c) Cemetery or crematory Modena Church
Location " Pa.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St

19 (Date received by registrar) MAY 4 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1944, 9.45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944 to May 2 1944, and that I last saw her alive on May 1 - 1944.

Immediate cause of death	Duration
Myocarditis	
Due to Advanced atherosclerosis	/
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis Daiker M. D.
Address 1700 Eutaw Pl. Date signed May 3-44

(17)

G 16839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town WASHINGTON
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES Joseph BURNS

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 220-09-4560

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1895

8. AGE: Years 48 | Months 11 | Days 5 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Unemployed Laborer

11. Industry or business

FATHER
12. Name James J. Burns
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna J. Burns
15. Birthplace Ireland

16 (a) Informant Margaret E. Doyle
(b) Address 4106 Walrad Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 317 St. Paul st.

19 (a) MAY 4 1944 Registrar Hampton Williams M.D.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944 at 10 30 A.M.

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning, accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3
(a) Date of injury at M.
(b) Where did injury occur? Foot of Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 4/18/44

G 16840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

G 16840 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Remington ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Remington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mitchell Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No. 242-20-8292

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1925

8. AGE: Years	Months	Days	If less than one day
19/8	-	27	hr. min.

9. Birthplace Winnsboro S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Elliot Johnson
13. Birthplace Winnsboro, S.C.

MOTHER
14. Maiden Name Maggie Irby
15. Birthplace Winnsboro, S.C.

16 (a) Informant Elliot Johnson
(b) Address 2807 Remington ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)

(c) Cemetery or crematory Winnsboro
Location S.C. Litchfield & Gaddis

18 (a) Funeral director 2181 McCulloh St.
(b) Address

19 (a) (Date rec'd by reg.) (b) JUN 4 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 29 1944 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Apr 28 1944 and that I last saw h alive on Apr 28 1944

Immediate cause of death Status Epilepticus. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo J. Julian Jr. M. D.
Address 511 N. Schroeder St. Date signed 5/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Light St.
(c) Hospital or institution: Md. Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Ld.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas McManus

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Alice E. McManus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 1880

8. AGE: Years 64 | Months ~ | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Night Watchman
11. Industry or business City of Baltimore

FATHER
12. Name John T. McManus
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Linton
15. Birthplace Ireland

16 (a) Informant Mr Melvin Fox
(b) Address 420 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Balto. Co.

18 (a) Funeral director Frederick C. Pole
(b) Address 1710 W Lombard St

19 (c) Filed [illegible] Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at 1.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1944 to 5/2 1944 and that I last saw him alive on 5/1 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 2 days
Due to: Hypertension c.v. disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature Paul A. Lukats M. D.
Address 213 Light St. Date signed May 5 1944

G 16842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16842 Registered No. 110a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 Myrtle Ave
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1907

8. AGE: Years	Months	Days	If less than one day
36 37	4	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Bogle
13. Birthplace Asheville N. C.

MOTHER
14. Maiden Name Anna Barnett
15. Birthplace Maryland

16 (a) Informant Anna Bogle
(b) Address 1345 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mortimer H. Hawkins
(b) Address 378 W. Biddle St

19 (a) (Date received by local registrar) (b)
MAY 4 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1944 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16- 1944 to 5-2 1944, and that I last saw h alive on 5-2-1944

Immediate cause of death Tuberculosis — Duration

Due to Empyema right Baltimore County

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-31-44

Major findings of operations: Empyema right pleural cavity

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Welcome M. D.
Address 1131 Harlem Date signed 5-3-44

G 16843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G 16843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 Camel Alley
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Camel Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1908

8. AGE: Years 35 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Peter Briscoe
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Ida Emmis
15. Birthplace Howard Co., Md.

16 (a) Informant Ida Briscoe
(b) Address 332 Camel Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 576 W. Fridder St.

19 (a) MAY 4 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
May 4 1944

VS-151

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

16844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 159

Registered No. 16844

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N. Bentalou St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY RUBENSTEIN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-44

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph G. Rubenstein
13. Birthplace Savannah Ga.

MOTHER 14. Maiden Name Bessie
15. Birthplace Balto Md

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-44 (month) (day) (year)
(c) Cemetery or crematory Jewish Cem
Location Baltimore Md

18 (a) Funeral director Jacob Levine
(b) Address 1439 E. Balto St

19 MAY 4 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3. 1944 at 8 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1944 to 5-3 1944, and that I last saw h alive on 5-3 1944

Immediate cause of death Premature ity (7m/ Duration

Due to (Debility)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Taylor

Address Date signed 5/3/44

16845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 16845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital, Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Sobkow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Meyer

13. Birthplace Russia

14. Maiden Name Tobie

15. Birthplace Russia

16 (a) Informant Hoyt Reeder

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Hyman Hall Rd

18 (a) Funeral director Jack Levy Co

(b) Address 1439 E. Balto St

MAY 4 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 29 1944 to May 3 1944, and that I last saw her alive on May 2 1944.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Cerebro-vascular accident

Due to Generalized Arteriosclerosis ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwards M.D.

Address Sinai Date signed 5/3/44

G 16846 ✓ G 16846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) q
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 E North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Berth M. Wild

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4th 1883

8. AGE: Years 60 | Months 6 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Poston
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Marion Wild
(b) Address 2209 E North Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof May 7, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd

18 (a) Funeral director Lee D Cook
(b) Address 1701-03 Pattison Ave

19 MAY 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 2 Dr Goldstone 2243 Linden Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2nd 1944 at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 to May 2 1944, and that I last saw h[illegible] alive on DEC. 1943.

Immediate cause of death	Duration
Coronary Occlusion	15 min.
Due to Coronary Sclerosis	10 yrs. +
Due to Arteriolosclerosis	?
Other Conditions Cerebral Hemorrhage	3 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Goldstone M. D.
Address 2243 Linden Av. Date signed May 3, 1944

(The 16847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

(C 16847 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. FOR BEYOND

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Joplin Street
(c) Hospital or institution:
Home 2610
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 S. Joplin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Koczorowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-03-5098

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20-1876

8. AGE: Years	Months	Days	If less than one day
68	3	13	hr min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Repair Man Car Shop
11. Industry or business B. & O. Railroad

FATHER
12. Name Fabijan Koczorowski
13. Birthplace Poland

MOTHER
14. Maiden Name Magdalena Kaczmarowski
15. Birthplace Poland

16 (a) Informant Michael Koczorowski (Son)
(b) Address 129 N. Linwood Ave

17 (a) Burial (b) Date thereof 5-8-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.
18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street
19 (a) MAY 4 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1944 at 5 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20, 1943, to May 3 1944, and that I last saw h— alive on May 3, 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	2 days
Due to	
Due to	
Other Conditions Malignancy of Liver and jaundice	several years

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury
23. Signature John J. Cooper M. D.
Address 2627 Eastern Ave Date signed 5/5/1944

16848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 16848

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4208 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada L. Morris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lysander M. Morris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 5-1881
8. AGE: Years 63 | Months — | Days 26 | If less than one day hr. min
9. Birthplace: Greenmount, Carroll Co Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

MOTHER / FATHER
12. Name: John Reaver
13. Birthplace: England
14. Maiden Name: Lizzie Grumb
15. Birthplace: Maryland

16 (a) Informant: Lysander M. Morris
(b) Address: 4208 Falls Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 4-1944 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore Co. Maryland
18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

MAY 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1- 1944, at 4.46 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1941 to May 1 1944 and that I last saw her alive on May 1, 1944
Immediate cause of death: Pneumonia Hypostatic Left side — Duration 2 days
Due Apoplexy Rt side — 2 yrs 10 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 403 Med Arts Bldg Date signed 5/3 1944

G 16849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G 16849 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 N Streeper St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 79yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hagest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John M. Hagest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 29-1865

8. AGE: Years 79 | Months — | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business at home

FATHER
12. Name George Smith
13. Birthplace Sweden

MOTHER
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant Mrs M. Hagest
(b) Address 103 N Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulbych Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by Registrar) (b) Registrar

MAY 6 1944

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1944 to May 3 1944, and that I last saw her alive on May 2 1944.

Immediate cause of death Bronchial Pneumonia — Duration 2 wks.

Due to Chronic myocarditis — Duration ?

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conal Gordon M. D.

Address 2201 W Wolfe St Date signed 5-3-44

16850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 16850

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: late Edward B. Harris
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July 3, 1860
8. AGE: Years 83. Months 9 Days 29 If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

MOTHER / FATHER
12. Name John. Vineyard
13. Birthplace Baltimore Md
14. Maiden Name Margaret Myers
15. Birthplace Germany.

16 (a) Informant Mrs Ella M. Harris
(b) Address 4509 Frederick Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.
18 (a) Funeral director John J. Howard & Son
(b) Address 901-03 Hollins Street
19 (a) (b)

MAY 4 1944 Huntington Williams M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1944 at 5:4. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1934 to May 2 1944 and that I last saw h alive on May 1, 1944.

Immediate cause of death: Arteriosclerosis — Duration: 10 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Pennington M. D.
Address 514 Druid Lane Date signed 5/3/44

G 16851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. REGISTERED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 W. Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 S. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Dill

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Irma R. Dill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1875

8. AGE: Years	Months	Days	If less than one day
68.	10	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business Bartlett Hayward Co.

FATHER
12. Name William Dill
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Lutz
15. Birthplace Germany

16 (a) Informant Mrs Irma R. Dill
(b) Address 719 W. Hamburg St

17 (a) burial (b) Date thereof 5/5/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Road.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-903 Hollins Street.

19 (b)
(Date rec'd by Registrar) Registrar

MAY 4 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1944, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 5-2 1944, and that I last saw h— alive on 5/2 1944

Immediate cause of death Bronchopneumonia — Duration 3 da.
Due to Generalized Sclerosis of Arteries — Duration Syr
Due to Arterio Cardio Vascular Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Laucardy M. D.
Address 6 Washington Blvd Date signed 5/4/44

G 16852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49D

G 16852
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilmor & Wilkens Ave
(c) Hospital or institution: St. Agnes Hosp 2068
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Potter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Violet Savage (SAVIDGE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late Albert Savidge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1887

8. AGE: Years 57 | Months 1 | Days 16 20 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Louis Roth dec'd
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Christina Mueller
15. Birthplace Balto. Md

16 (a) Informant Mrs. Alice Schulz
(b) Address 4709 Potter Ave

17 (a) Burial (b) Date thereof May 6, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Northwood
Location Philadelphia Pa

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MAY 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1944 to 5-3 1944 and that I last saw her alive on 5-3 1944

Immediate cause of death: Carcinomatosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature W. E. McGrath M.D. M. D.
Address St. Agnes Hosp Date signed 5/3/44

G 16853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 16853 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Gywnns Falls Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) The Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Edward Ludwig

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1866

8. AGE: Years 77 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Karl E. Ludwig
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Ludwig Sommes
15. Birthplace Germany

16 (a) Informant William R. Ludwig
(b) Address 3113 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave. Balto. Md.

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave

19 MAY 4 - 1944 (Date rec'd by local reg.) Huntington Williams M.D.

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944, at 9.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1- 1943, to May 3- 1944, and that I last saw h[illegible] alive on April 29 1944.

Immediate cause of death: Carcinoma of Intestines — Duration: 2 years

Due to:

Due to:

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation December 1942

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Roland M. D.

Address 2532 Edmondson Ave. Date signed 5-3-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

451085, 16854 BALTIMORE CITY HEALTH DEPARTMENT X V 6, 16854

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town xxxxxxxxxxx Orchard Pk. (If outside city or town limits, write RURAL and give town)
(d) Street No. xxxxxxxxxxxxxxxxxxxxxxxxxxx (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Gordon I Trevett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife Virginia
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 11-28-11

8. AGE: Years 32 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation PHYSICIAN
11. Industry or business

FATHER — 12. Name Ira P Trevett
13. Birthplace N.Y.

MOTHER — 14. Maiden Name Anna Davis
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory
Location Buffalo, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 4 - 1944 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1944, to May 3 1944, and that I last saw him alive on May 3 1944.

Immediate cause of death Carcinomatosis with metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of colon.

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Bruenlach M.D.
Address Johns Hopkins Hospital Date signed 5/3/44

Dr/6446 Hanover G 16855 ✓ G 16855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. See correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 S. Gilmor St -
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 S. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Imasingo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widower

6 (b) Name of husband or wife Katherine Imasingo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 - 1872

8. AGE: Years	Months	Days	If less than one day
71 72	11	25	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Memorial business

FATHER
12. Name John H. Imasingo
13. Birthplace Balto Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto - Md

16 (a) Informant Mrs. Edna Vickers
(b) Address 909 N. Gilmor St.

17 (a) Burial (b) Date thereof May 5 - 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. Md.

18 (a) Funeral director Mamie Cook Lyfer
(b) Address 1600 N. North Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944, at 1-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1944 to May 2 1944 and that I last saw alive on May 1 1944

Immediate cause of death

	Duration
Acute dilatation of Heart	2 days
Due to Acute Intestinal Obstruction	
Due to	
Other Conditions Bronchial Asthma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature P. L. Campobasso M. D.
Address 1644 Hanover Date signed May 3/44

Chlorice

16856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 16856

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chlorice Ann Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1926

8. AGE: Years 17 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Ernest Cooper

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Rachel Thompson

15. Birthplace Baltimore Md

16 (a) Informant Rachel Cooper

(b) Address 1332 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Wm. George W. Holland

(b) Address 1642 Druid Hill Ave

19 (a) MAY 4 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1944, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to April 29, 1944, and that I last saw h alive on 4/29/1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 4 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature [illegible] M.D.

Address 2242 Linden Ave Date signed 5/3/44

16857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 16857

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 Dr. Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Dr. Hill Ave.
(If rural give location)
(e) Citizen of foreign country? —(Yes or No)
If yes, name country

3 (a) FULL NAME Mary Powell

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15. 1873

8. AGE: Years	Months	Days	If less than one day
70 71	11	17	hr. min.

9. Birthplace Howard Co. Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Home work

FATHER
12. Name Michael Powell
13. Birthplace unknown

MOTHER
14. Maiden Name Rosie Dorsey
15. Birthplace unknown

16 (a) Informant Mrs. Rosie Harris
(b) Address 1836 Dr. Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto Md.

18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 1631 Druid Hill Ave

MAY 4 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) (Address) 1630 N. Fremont Ave. Date signed 5/2/44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1943 to May 2 1944, and that I last saw h alive on May 1 1944

Immediate cause of death Cerebral Hemorrhage — Duration 4 hrs/days

Due to —

Due to Hr. Valvular Heart Disease (Mitral Insufficiency) 1939

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature Janet Brown

G 16858 Wood Turner. Dr. Paul Brown. DeBow G 16858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1649 Gorsuch Ave
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilbur N. DeBow.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower.

6 (b) Name of husband or wife Mary E. DeBow.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1875

8. AGE: Years	Months	Days	If less than one day
68	11	7	hr. min.

9. Birthplace Maryland. (town, county, and state)
10. Usual Occupation Retired machinist
11. Industry or business Navy Yard, Work B.6.

FATHER
12. Name Nicholas DeBow.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E. Robertson
15. Birthplace Maryland.

16 (a) Informant Robert E. Sherman.
(b) Address 1204 W 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Edmondson & Donovan
(b) Address 2400 Eastern Ave.

MAY 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944, at 4 25/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944 to May 3 1944. and that I last saw h alive on May 3 1944

Immediate cause of death: Cerebral Hemorrage — Duration 5hr/4a

Due to: Chr. Myocarditis — 1934

Due to: Arteriosclerosis — 1934

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1663 W. North Ave. Date signed 5/4/44

Zofia Wadsik

16859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C 16859

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 Fleet
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Zofia Wojcik

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Wojcik (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years >4 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name ? Pupa

13. Birthplace Poland

MOTHER — 14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mrs Catherine Dringer

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore Catholic

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

(c) MAY 4 1944 (Date of registration) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 815

20. DATE OF DEATH May 2 1944, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1942 to May 2 1944, and that I last saw h[illegible] alive on May 2 1944.

Immediate cause of death: Acute cardiac dilatation — Duration: 2 days

Due to: Chronic myocarditis — 4 yrs.

Due to: Hypertension — 4 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Gasparski M. D.

Address 9802 Eastern Ave Date signed 5-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 16860

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 512 Druid Hill Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 512 Druid Hill Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	married

6 (b) Name of husband or wife Willie

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1911

8. AGE: Years	Months	Days	If less than one day
33	3	17	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER 12. Name Robert Curtiss

FATHER 13. Birthplace Southport, N.C.

MOTHER 14. Maiden Name Mary

MOTHER 15. Birthplace North Carolina

16 (a) Informant Willy Jackson

(b) Address 512 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/44 (month) (day) (year)

(c) Cemetery or crematory Wilmington

Location North Carolina

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

19 (a) MAY 4 1944 (Date received) (b) Huntington Williams, M.D. Registrar

VS 15c

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1943 to May 2 1944 and that I last saw her alive on May 2 1944.

Immediate cause of death	Duration
Chronic Myocarditis	7
Due to	1
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edw. J. Mc Dalley M. D.

Address 230 Druid Hill Ave. Date signed 5/2/44

16861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G 16861 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 D. St. on
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 D. St. on (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus Robinson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 68 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Ida Henry
(b) Address 703 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Hasket Derby
(b) Address 918 Druid Hill Ave

MAY 8 - 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/44 19 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26/44 to 5/1/44.
and that I last saw h[illegible] alive on 5/1/44.
Immediate cause of [illegible] Cerebral Hemorrhage — Duration 4 hrs
Due to Chronic Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. C. Eaton M. D.
Address 5 E. Mt. Royal Ave Date 5/3/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

G 16862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 6

G 16862 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 W Lanvale
(c) Hospital or institution:
Lydenham 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 W Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gordon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Sarah Gordon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16, 1905

8. AGE: Years 39 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace So Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Gordon
13. Birthplace S Carolina

MOTHER
14. Maiden Name Sarah Jones
15. Birthplace S Carolina

16 (a) Informant Mary Miller
(b) Address 638 N Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAY 4 1944 (Local registrar) (b) Huntington Mills, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 19 44 to 5/1 19 44 and that I last saw h-- alive on 5/1 19 44

Immediate cause of death: Resp failure — Duration: 4 Hrs
Due to: meningitis
Due to: ? meningococcus
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Kaye
Address Lydenham Date signed M D 5/2/44

CARWIARY

16863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 16863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Warner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Warner St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Carwiary

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Roy Carwiary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1894

8. AGE: Years 50 | Months 32 | Days 22 | If less than one day hr. min.

9. Birthplace Cross Hill S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jess Cuningham
13. Birthplace S C

MOTHER
14. Maiden Name Sermeadon Bullitt
15. Birthplace S C

16 (a) Informant Roy Carwiary
(b) Address 905 Warner St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Branch
(b) Address 1844 Montgomery St

19 (a) MAY 4 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2/ 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1944 to 5/2 1944 and that I last saw h— alive on 5/1 — 1944

Immediate cause of death: Hypertension Cardio Renal Disease — Duration 5 Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Stapleton

Address 1232 Pa Ave Date signed 5/3/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 16864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly, and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4th Belt. + Keswick Rd.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 18 days.
(e) Length of stay in Baltimore (yrs., mos., or days) For ever.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Wilhelmina Albaker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a). Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Chester Henry Albaker 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1869

8. AGE: Years	Months	Days	If less than one day
74	4	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Woeff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Augusta Aebnecker
15. Birthplace Germany

16 (a) Informant Home for Incurables.
(b) Address 700 W 40th St. Balto.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director F. D. Wappaus & Son
(b) Address 800 Eastern Ave.
19 (a) MAY 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1944, at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938 to May 3rd 1944, and that I last saw her alive on April 1944.

Immediate cause of death: Coronary Thrombosis — Duration 15 mins.
Due to: Arteriosclerotic Cardio-Vascular Disease — 42 years
Due to:
Other Conditions: Old traumatic paraplegia, lower extremities
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Aubrey Woeff
Address 11 E. Chase St. Baltimore MD. Date signed 5/5/44

G 16865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16865 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1922 Christian st.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin J. Ehatt

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-4457

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12-1882

8. AGE: Years	Months	Days	If less than one day
64	3 23	21	— hr. — min.

9. Birthplace Baltimore, Md (Town, county and state)
10. Usual Occupation Brewing Business
11. Industry or business Free State Brewery

FATHER
12. Name Geo Ehatt
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Kattie
(b) Address 2144 Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director F. B. Wagner & Son
(b) Address 320 Eutaw Place
1944 MAY - 1944
(Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1944, at 5:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944 to 5/2 1944 and that I last saw h[im] alive on 5/2 1944.

Immediate cause of death	Duration
Arteriosclerotic cardio Vascular disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 700 Wilkens ave Date signed 5/4/44

G 16866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16866 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 Ruskin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Ruskin Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Maude Shipley Zimmerman

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Leo Albert Zimmerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1887

8. AGE: Years 56 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Lewis Shipley
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Eliza Ellen Shipley
15. Birthplace Howard Co. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Dorsey, Md.

18 (a) Funeral director Easton Long
(b) Address 608 Frederick Ave

19 (a) (Date rec'd by registrar) MAY 4 - 1944 (b) Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944 at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to May 2 1944, and that I last saw h[illegible] alive on May 1st 1944.

Immediate cause of death — Duration
(1) Cerebral Hemorrhage — 3 days
Due to: Arterio-Sclerotic Heart — 8 yrs.
Due to: Diabetes & Concomitant Intoxication
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4104 LIBERTY HEIGHTS AVE. Date signed 5-3-44

G 16867

AB-86189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 D

G 16867

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months- 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 426 Myrtle Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-11,1883

8. AGE: Years 60 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Ga.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Isaac Harris (D)

13. Birthplace Ga.

MOTHER

14. Maiden Name Charity Arnold (D)

15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 4 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 4 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

10918

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 11.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944, to 4/16 1944, and that I last saw h[illegible] alive on 4-16 1944.

Immediate cause of death

? Coronary Occlusion

Duration 8 hours

Due to Syphilitic Aortitis

Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Hatton M.D.

Address B.C.H. Date signed 4/20/44

16868

AB-87555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16868 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hosptials
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11hrs.55Min
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 48? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by reg.) MAY 4 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22- 1944, at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1944 to 4/22 1944, and that I last saw him alive on 4/22 1944.

Immediate cause of death Coma
Pneumonia, Pneumococcic meningitis | Duration ?
Due to
Due to
Other Conditions Dehydration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergmon M.D.
Address BCH Date signed 5/2

0917

G 16869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 16869 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 E. West St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Underwood.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1872

8. AGE: Years	Months	Days	If less than one day
71	7	20	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self employed

FATHER
12. Name Alfred L. Underwood
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Susan E. Pryor
15. Birthplace Balto

16 (a) Informant William E. Underwood
(b) Address 25 E West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Elder Hill
Location Ar. A. Lo
18 (a) Funeral director C. Howard Evans
(b) Address 1400 Sb Charles St
(c) [illegible] 1944 [illegible] Washington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944, at 2.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1944, to 5/2 1944, and that I last saw him alive on 5/2 1944.

Immediate cause of death	Duration
Hypertensive C.V. disease	
Due to	
Due to	
Other Conditions Pernicious anemia (Include pregnancy within 3 months of death)	10 y.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H. Luckett M. D.
Address 1213 Light St. Date signed May 7/1944

G 16870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16870 Registered No.

VA-76519 13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1, 7, 28
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 E. West St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glenn Russell Blickenstaff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie H. Blickenstaff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1901

8. AGE: Years	Months	Days	If less than one day
43	~	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Airplane Mechanic Foreman
11. Industry or business Glenn L. Martin

FATHER
12. Name William Blickenstaff
13. Birthplace Maryland

MOTHER
14. Maiden Name Floy Morgan
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location a. A. b.

18 (a) Funeral director A. Howard Evans
(b) Address 1406 Charles St
(c) (Date rec'd by registrar) MAY 4 - 1944 Thurlington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1944 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1942 to 5/2 1944.
and that I last saw him alive on 5/2 1944.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. Abbe

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mathe M. D.
Address BCHA Date signed 5/3/44

G 16871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G 16871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: So. Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name of county)
(d) Street No. 106 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina James

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles James Deceased | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1865

8. AGE: Years 78 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Edgar C. Gunther Jr. (b) Address 1507 Eldorado St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6, 1944 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem. Location Balto Co., Md.

18 (a) Funeral director A. Howard Evans (b) Address 1400 E. Chas. St. Balto. Md.

19 (a) MAY 8 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944, at 9:45 A M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of Chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-2-44 at 9:30 P. M. 23/3
(b) Where did injury occur Hanover & Fort Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Auto.

23. Signature W. L. Wollenweber M.D. Medical Examiner.
Date signed May 3, 1944.

VS 161-

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16872 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Ward or address 2401 Smith ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Smith Ave
(If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E McFarland

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles McFarland
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 25, 1881

8. AGE: Years 63 | Months 1 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Fort Washington Md
(Town, county and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Don't know
13. Birthplace 11 11

MOTHER
14. Maiden Name — Leech
15. Birthplace Md

16 (a) Informant Mrs Marion Burn
(b) Address 521 Wyeth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ga. Co

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St

19 (a) ____ (Date rec'd by registrar) (b) ____ (Registrar)

MAY 4 - 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944 at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943, to May 3 1944, and that I last saw h[er] alive on May 3 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 3 months

Due to: Arteriosclerosis Generalized — 2 years

Due to: ____

Other Conditions: Diabetes Mellitus — 3 years
(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Paul Schofield
Address 521 Wyeth St Date signed 5/4/44 (M/D/Y)

G 16873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16873 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Lutland Ave
(c) Hospital or institution:
Sinai Hospital 1422
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10½hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10½hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Eutaw Place--17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lipschitz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1944

8. AGE: Years	Months	Days	If less than one day
			10 hr. 30 min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Abe Lipschitz
13. Birthplace Iowa

MOTHER
14. Maiden Name Doris Hellman
15. Birthplace New York City

16 (a) Informant Abe Lipschitz
(b) Address 2018 Eutaw Place

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 MAY 4 1944 (Date Rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944, at 5 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1944 to 4-22 1944 and that I last saw h~~im~~ alive on 4-22 1944

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond B. Heatberg M.D.
Address Sinai Hosp Date signed 4-26

VS 2

09:20

G 16874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16874
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3435 Mayfield Ave --13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Girl Mariany

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1944

8. AGE: Years | Months | Days | If less than one day: 17 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Mariany
13. Birthplace New York City N Y

MOTHER
14. Maiden Name Doris Whitker
15. Birthplace Merry Point Va

16 (a) Informant Doris Mariany
(b) Address 3435 Mayfield Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 4 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1944, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1944, to 4/18 1944 and that I last saw h[illegible] alive on 4/18 1944.

Immediate cause of death Prematurity | Duration
Due to
Due to
Other Conditions Premature Separation of placenta in deceased's mother
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilfred K Konigsberg M. D.
Address 2240 Eutaw Pl Date signed 4/19/44

0919

G 16875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16875 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flat Street
(c) Hospital or institution P.D. K

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and State)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Albert Stevenson
13. Birthplace

MOTHER
14. Maiden Name Arlene
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAY 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 4 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1944 at 1 30 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Prematurity (7 mo)
Atelectasis neonatorum.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester L. Lubinski M.D. Medical Examiner.
Date signed 4/13/44

PRINT WRITE PLAINLY, with ink. Cross out the words not necessary to answer. Every question must be answered. Where there is no person in charge of the body, the coroner must be notified at once. Do not report "cancer," "tumor," "stroke," "heart trouble," "old age" or "senility" as the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

16876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 159

(1) 16876

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 S. Carrie St (If rural give location)
(e) Citizen of foreign country? Cousin Y (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Johnston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
—	—	1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY MAY 4 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAY 4 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed April 3, 1944

C 16877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#4 / 94a

C 16877 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-0.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME UNIDENTIFIED COLORED MALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAY 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 4 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 44, at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. T. Z. Wallenstein M.D.
Asst. Medical Examiner.
Date signed 4-6-44

450723 G 16878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G 16878 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Ca. (b) County
(c) City or town Salisbury (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 W. Council St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin H. McCutchins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sara

6 (c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): 10-7-90

8. AGE: Years 53 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace: N. Ca. (Town, county, and state)

10. Usual Occupation: Clerk of Superior Court.

11. Industry or business

FATHER — 12. Name: Thomas McCutchins

13. Birthplace: N. Ca.

MOTHER — 14. Maiden Name: Ruda Spencer.

15. Birthplace: N. C.

16 (a) Informant: Rescuda.

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5-4-44 (month) (day) (year)

(c) Cemetery or crematory

Location: Salisbury, N. C.

18 (a) Funeral director: Wm. J. Thelen & Son

(b) Address: North Person Ave.

19 (a) (Date received) (b) Registrar: Huntington Williams, M.D.

MAY 4 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1944 at 12.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1944 to May 4 1944 and that I last saw h[illegible] alive on May 4 1944

Immediate cause of death: Respiratory failure — Duration:

Due to: arteriosclerotic heart disease & cardiac failure

Due to:

Other Conditions? CA of retroperitoneal & metastases to liver

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. Bernstein

Address: J. H. H. Date signed: 5-4-44

G 16879 ✓ G 16879

Frederick P. Wieland

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Rosedale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frederick P Wieland

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-0554

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1880

8. AGE: Years	Months	Days	If less than one day
63	10	18	hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Retired United Railways

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Earl D Hare
(b) Address 905 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Geo M Little
(b) Address 2700 Edmondson Ave

19 (a) [illegible] Baltimore, Md.

MAY 5 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 2 1944 and that I last saw him alive on May 2 1944

Immediate cause of death Respiratory failure — Duration

Due to Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clift Routh M.D. M. D.
Address University Hosp Date signed May 3 1944

M D. R. 1288-9

16880 HEALTH DEPARTMENT—CITY OF BALTIMORE

G 16880

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2426 Liberty Heights Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Emma M. McGlone

(a) Residence: No. 2426 Liberty Heights Ave. St., 15-5 Ward.
(Usual place of abode) (If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. McGlone

6. DATE OF BIRTH (month, day, year) ?

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	80			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Harry L. Bressler

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Rachel Andre

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mr. Marion L. Elliott

(Address) 2426 Liberty Heights Ave.

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Loudon Park Cem Date 5/5/44, 19

19. UNDERTAKER John O. Mitchell & Sons, Inc.

(Address) 1900 Eutaw Place

20. FILED MAY 5 - 1944 19 Hunter for Wilmer, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 2, 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb 3, 19 44, to May 2, 19 44

I last saw her alive on May 1, 19 44. Death is said to have occurred on the date stated above, at 6 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1940
Chr Myocarditis	1940
Other contributory causes of importance:	
Carbuncle Hemorrhage	1944

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) B. W. Bishop, M. D.

(Address) 501 S Lundenwood

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FL - 87614 G 16881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 7
(d) Street No. 511 S. Lehigh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Hodulik

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Angela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1897

8. AGE: Years	Months	Days	If less than one day
46	6	17	hr. min.

9. Birthplace Czechoslovakia (city, county, and state)
10. Usual Occupation Shipfitter
11. Industry or business Beth. Steel

FATHER
12. Name Marty Hodulik
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Elizabeth Smolek
15. Birthplace Czechoslovakia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Sacret Heart Cemetery
Location German Hill Road

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison Street.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3 1944, at 2 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1943 to 5-3 1944, and that I last saw h[illegible] alive on 5-2 1944.

Immediate cause of death	Duration
Ruptured peptic ulcer	?
Due to Pneumoperitoneum	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Martone M. D.
Address P. O. 11 Date signed 5/4/44

G 16882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 16882 Registered No.

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Mohawk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HATTIE GILLET PURDY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: C. Melvin Purdy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 24, 1865

8. AGE: Years: 79 | Months: 1 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Scio, N. Y. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Edward Gillet
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Adelia Stout
15. Birthplace: Friendship, N. Y.

16 (a) Informant: Mr. C. Melvin Purdy
(b) Address: 3604 Mohawk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944 at 7:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1944, to 5/2 1944, and that I last saw her alive on 5/2 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	Sudden
Due to Arteriosclerosis	2 days
Due to	
Other Conditions Myocarditis	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wesley Edel D/
Address 3403 Eastern Blvd Date signed 5/4/44

G 16883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16883 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lourd Bros. Bur. Hospital 1507
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Clifton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leonard Turner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1884

8. AGE: Years 59 | Months 8 | Days 23 | If less than one day 1884 hr. min.

9. Birthplace Alban, Md. (Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business Coca Cola Co

FATHER
12. Name William Turner
13. Birthplace Salisbury, Md.

MOTHER
14. Maiden Name Jennie Malone
15. Birthplace Salisbury, Md.

16 (a) Informant Annie Turner
(b) Address 2818 Clifton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/44 (month) (day) (year)
(c) Cemetery or crematory Oakleyn Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tucker & Son
(b) Address Balto Md.

19 (a) MAY 5 - 1944 (Date received by registrar) Huntington Whitehurst, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3-1944 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Muldeis M.D. Medical Examiner.
Date signed 5-4-44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 16884

~~16884~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Bonner Ave.
(c) Hospital or institution:
2716
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 Dupont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha Katzoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Jacob Katzoff
13. Birthplace Russia

MOTHER 14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Mollie Goldsmith
(b) Address 3422 Dupont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowley Land

18 (a) Funeral director Sol Levinson Bros.
(b) Address 1124-26 W Northave

19 (a) (Date rec'd by registrar) (b)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Information should be obtained from the nearest relative or other informant if there is no physician in attendance. Please give the correct age in every case. Accuracy in stating the age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944, at 6:30 P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cerebral embolism
cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed May 5, 1944

G 16885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16885 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Morrissett

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-7816

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Ruth M. (nee Arnold)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1879

8. AGE: Years	Months	Days	If less than one day
64	10	27	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Harp + Uke-Retired

11. Industry or business

FATHER
12. Name Charles Morrissett
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs. Ruth M. Morrissett
(b) Address 1221 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Whittle
(b) Address 401 E. Edmondson Ave. Huntington Apartments, Md.

19 (a) MAY 5 - 1944 Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2/44 19 , at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1939 to May 2 1944 and that I last saw him alive on May 1 1944.

Immediate cause of death Cerebral hemorrhage hemiplegia — Duration 5 days

Due to Generalized arteriosclerosis with hypertension

Due to

Other Conditions Arteriosclerotic typ. Left hip fx. with hypertrophy of prostate gland

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel, M. D.
Address 2901 Edmondson Ave Date signed May 3 44

16886

HEALTH DEPARTMENT—CITY OF BALTIMORE

16886

CERTIFICATE OF DEATH 1944

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OR BALTIMORE: (No. 1519 Shields Place St., ... Ward)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

If U. S. Veteran specify WAR.....

2. FULL NAME Lemmy Griffin

(a) Residence: No. 1519 Shields Place St., 14-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Wh.	widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John

6. DATE OF BIRTH (month, day, year) 1872

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Raff Ball

14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME Sherria Waters

16. BIRTHPLACE (city or town) (State or country) Virginia

17. INFORMANT Mrs. H. Griffin

(Address) 1519 Shields Place

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Cem Date May 6 1944

19. UNDERTAKER George H. Kelson

(Address) 1303 P[redacted] St

20. FILED MAY 5 1944 Harrington Williams M.R.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 4 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb 4 1944 to May 4 1944

I last saw h[er] alive on May 4 1944 Death is said to have occurred on the date stated above, at 5.45 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	?
	1

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Edward J. Wheatley M. D.

(Address) 1730 Linden Ave

V8 2

Information should be carefully supplied. And it may be properly classified. Exact statement of state CAUSE OF DEATH in plain terms, so that it OCCUPATION is very important. See instructions on back of certificate.

G 16887

G 16887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (581)

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street.
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5060 E Federal St. (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Linda Diane Floyd

3 (b) If veteran, name war .....
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Child

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1938

8. AGE: Years	Months	Days	If less than one day
6	3	9	hr. ..... min.

9. Birthplace Alabama City, Ala. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Vernon F. Floyd
13. Birthplace Alabama City, Ala.

MOTHER
14. Maiden Name Catherine Hines
15. Birthplace Alabama City, Ala.

16 (a) Informant Vernon F. Floyd
(b) Address 5060 E. Federal st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Forest Senegal
Location Dadeseden, Alabama.

18 (a) Funeral director Leonard J. Ruck
(b) Address 3305 Harford Rd

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAY 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1944, at 9 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1944 to 5-4 1944 and that I last saw her alive on 5-4 1944.

Immediate cause of death Rheumatic Heart Disease — Duration .....
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: Pancarditis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 5-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16888 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 83a

G 16888 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Northway Dr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Northway dr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Constance

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Viola M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1878

8. AGE: Years	Months	Days	If less than one day
65	7	18	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Viola Constance
(b) Address 3016 Northway drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b)

MAY 5 - 1944

Funeral by Wm. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to May 3 1944, and that I last saw him alive on May 2 44

Immediate cause of death	Duration
Cerebral hemorrhage	10 hrs
Due to Malignant hypertension	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harrold M.D. M. D.
Address 4706 Harford Road Date signed 5/3/44

2

G 16889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 16889 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 Alvarado Sq.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Alvarado Sq. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry F. C. Nieberlein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louise A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1878

8. AGE: Years 65 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Steel Molder

11. Industry or business J. J. Lacy Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Louise Nieberlein
(b) Address 2820 Alvarado Sq.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 5 - 1944

Victor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944, at 8:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to May 2 1944, and that I last saw him alive on May 2 1944

Immediate cause of death: Myo-carditis — Duration: 6 mo

Due to: Bronchostenosis — Duration: years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2824 St. Paul St Date signed May 3-44

G 16890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 f

G 16890

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Overhill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert D. Tweeddale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ethel Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1880

8. AGE: Years 64 | Months 8 | Days 25 | If less than one day hr. min.

63

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business

FATHER
12. Name Robert D. Tweeddale
13. Birthplace Scotland

MOTHER
14. Maiden Name Helen Dickson
15. Birthplace Scotland

16 (a) Informant John C. Dugan
(b) Address 116 Overhill Road

17 (a) Burial (b) Date thereof May 5, 1944
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director Edwin Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 5 1944 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1944, at 12:55 P.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head and body.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 20/2 600 ft. N. Mill
(a) Date of injury May 4, 1944 A.M.
(b) Where did injury occur? Penna. R.R. tracks
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Struck by train

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed May 6, 1944

G 16891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16891 Registered No. 808

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga 27
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 Crofton Road (If unnumbered give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Wolfe Gerhardt – Regina E. Gerhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Gerhardt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1884

8. AGE: Years 60 Months 1 Days 20 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Wolfe
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Ott
15. Birthplace Maryland

16 (a) Informant John Hunt
(b) Address 1328 Crofton Road

17 (a) Burial (b) Date thereof 5/6/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory N. C. Phoenix Cem
Location O/a Frederick Avenue

18 (a) Funeral director M. W. F. Lippe Sons
(b) Address Lombard & Ann Sts.

19 (a) (Date received by registrar) MAY 5 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/1944 at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6, 1944 to May 5, 1944 and that I last saw h[illegible] alive on May 3, 1944

Immediate cause of death: Cardio Respiratory Failure — Duration: 6 weeks

Due to: Acute Encephalitis

Due to:

Other Conditions: Pernicious anemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 5 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R Davis M.D.
Address Mercy Hospital Date signed 5/4/44

G 16892 ✓ G 16892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 9/7/43 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Wright Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN DEWEY HARRISON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mildred E. Harrison (Single Name-Wolfe) 6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 9/30/1898

8. AGE: Years 45 | Months 7 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Tilghmans Island, Md. (Town, county, and state)

10. Usual Occupation Mate - Merchant Marine
11. Industry or business

FATHER
12. Name Benj. T. Harrison
13. Birthplace Tilghmans, Md.

MOTHER
14. Maiden Name Irene G. Harrison
15. Birthplace Tilghmans, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem Cemetery
Location Taylor Ave

18 (a) Funeral director William M Mareck
(b) Address 715 Light St

19 (a) ... (b) ... (Undertaker's signature) Registrar

MAY 5 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION P.

20. DATE OF DEATH May 1, 1944, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1943, to May 1, 1944, and that I last saw him alive on May 1, 1944.

Immediate cause of death Dermatomyosarcoma with extensive multiple metastasis of skin, suboutaneous xxxx tissues & most all internal organs — Duration 3/1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 5/3/44-Excision of tumor, chest wall.
Major findings of operation: Tumor excised

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Williams
Address Baltimore, Md. Date signed 5/2/44

MS-47871

G 16893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G 16893 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 Calvert 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eleanor Chamberlain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Wid.

6 (b) Name of husband or wife Phillip William C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 31 Dec. 1877

8. AGE: Years 66 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Wagner
13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Bailey
15. Birthplace Maryland

16 (a) Informant Mrs. Lemmon Porter
(b) Address 913 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Earl L. Hess
(b) Address 712 Light St.

19 (a) (Date received by registrar) (b) Registrar

MAY 5 1944

VS 180 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/44 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 April 1944 to 3 May 1944, and that I last saw h[illegible] alive on 3 May 1944

Immediate cause of death Cardio-respiratory failure due to

	Duration
Due to post-operative acute pancreatitis	2 days
Due to carcinoma of stomach.	mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/28/44
Major findings of operation: carcinoma of stomach.
If autopsy: acute pancreatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chaffee M. D.
Address Union Mem. Hosp. Date signed 5/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 87223 5894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a G 16894 Registered No.

25-2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Veronica Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Baker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lona Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1876

8. AGE: Years	Months	Days	If less than one day
68	3	0	hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Watchman
11. Industry or business: Brown Cork & Seal

FATHER
12. Name: Isigar Baker
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: Germany

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory: Most Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: Carl L. Hess
(b) Address: 715 Light St.

19 (a) (Date rec'd by local reg.) (b) Registrar

MAY 5 1944 Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1944 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1944 to 5/2 1944 and that I last saw him alive on 5/2 1944

Immediate cause of death: Ca of esophagus (upper 1/4) & metastases — Duration: 7

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: metas. to liver & pleura

of autopsy: med. model

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Seymour M.D.
Address BCH. Date signed 5/2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~C~~ 16895 V G 16895 Registered No. 22a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Dickey Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1941

8. AGE: Years 3 | Months | Days | If less than one day hr. min.

9. Birthplace Washington, D. C. (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George Dickey Sr.
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lavenia Fuller
15. Birthplace South Carolina

16 (a) Informant Jas Bullock
(b) Address 820 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAY 5 1944 (b) Huntington Williams, M.D.
VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2/44 19 , at 6:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1944, to 5/3 1944, and that I last saw h. alive on 5/2 1944.

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to Miliary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation [redacted]
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hospital Date signed 5/3/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183 Registered No. G 16896

G16896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Boston (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 19 Blue Hills Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Spellman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: IDA NEE GROSSMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years 49 | Months | Days | If less than one day: hr. min.

9. Birthplace: RUSSIA (Town, county, and state)

10. Usual Occupation: MERCHANT MARINE SEAMAN

11. Industry or business

FATHER 12. Name: AARON SPELLMAN
13. Birthplace: RUSSIA

MOTHER 14. Maiden Name: BESSIE COHEN
15. Birthplace: RUSSIA

16 (a) Informant: JAMES SWERLING (BRO-IN-LAW)
(b) Address: 185 SAIRMONT ST. DORCHESTER, Mass.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 5-5-44 (month) (day) (year)
(c) Cemetery or crematory: JEWISH CEMETARY
Location: BOSTON, MASS.

18 (a) Funeral director: JACK LEWIS, INC.
(b) Address: 1431 E. BALTO. ST.

19 (a) MAY 5 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at 11:00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Late death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6

(a) Date of injury April 26, 1944 M.
(b) Where did injury occur? Canton R.R. Pier, Canton
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell while leaving ship

23. Signature Robert L. Grattan M.D. Medical Examiner.

Date signed May 5, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 16897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 McElderry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 McElderry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy L. Ogden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1916

8. AGE: Years	Months	Days	If less than one day
27	9	15	20 hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William C. Cane
13. Birthplace Taylor Island Maryland

MOTHER
14. Maiden Name Sarah Ellis
15. Birthplace Taylor Island Maryland

16 (a) Informant Sarah Ellis
(b) Address 1609 Mc Elderry st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7-44 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Brightville Md.

18 (a) Funeral director Lewis A. Henry
(b) Address Cambridge Md.

19 MAY 5 - 1944 Huntington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1944, to 5/4 1944, and that I last saw h[illegible] alive on 5/3 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration Couple yrs

Due to

Due to

Other Conditions Recurrent Pulmonary Hemmorrhage — 3 days

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L. Young M. D.

Address 1424 E. Monument St Date signed 5/4/44

16898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1610

G 16898

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 W. Lexington St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Mashone Bonnet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-44

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mashone Bonnet
13. Birthplace Gaffney - S.C.

MOTHER
14. Maiden Name Carrie Mae Manning
15. Birthplace Gaffney - S.C.

16 (a) Informant Mrs. Mashone Bonnet
(b) Address 1906 W. Lexington St.

17 (a) Burial (b) Date thereof May 5 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar)

MAY 5 1944

W 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 1944, at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to N.S death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis Neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. Katie L. Tubman M.D.
Medical Examiner.
Date signed 5/3/44

16899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

172

G 16899

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. D. Sykesville
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles O. Wright

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1902

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) March 31, 1905

8. AGE: Years 39 | Months 1 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name William W. Wright
13. Birthplace Maryland

MOTHER
14. Maiden Name Estella M. Harvey
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Wright
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-44 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Holy Family
Location Harrisonville Balto. Co.

18 (a) Funeral director C. M. Ward
(b) Address Westfield Md.

MAY 5 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1944, at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury May 4, 1944 9:30 A.M. 25/6
(b) Where did injury occur? Bethlehem-Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Explosion on ship

24. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed May 5, 1944

G 16900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 16900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore City, Maryland~~
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 E. Eager Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Spence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1862

8. AGE: Years 72 | Months 3 | Days 26 | If less than one day hr. 18 min. 42

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George W. Norrest
13. Birthplace Matthews Co. Va.

MOTHER
14. Maiden Name Harriet J. Martin
15. Birthplace Va.

16 (a) Informant Sadie Lehigh
(b) Address West Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave + Rose Hill

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

19 MAY 5 - 1944 Washington Williams, Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944, at 6:40 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage,

Due to arteriosclerosis,

Other Conditions ---

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed May 3, 1944.

V8 151

C 16901 16901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. C 16901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street City Harbor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town, give RURAL route and give name of county)
(d) Street No. 1417 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geo. S Timms

3 (b) If veteran, name war ? | 3 (c) Social Security Account No. ?

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married ?

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name John Sims
13. Birthplace Md

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Md

16 (a) Informant Nellie Timms
(b) Address 417 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/44 (month) (day) (year)
(c) Cemetery or crematory Curtis Bay
Location

18 (a) Funeral director McDaniel & Wellman
(b) Address 3221 Schroder St

19 (a) (b) Huntington Williams, M.D. Registrar.

MAY 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28-1944, at 9:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 4/28/44 at Inner Harbor 3/2 M.
(b) Where did injury occur? Harbor, Foot Dock St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury. Found Drowned

23. Signature Howard J. Weidler M.D.
Medical Examiner.
Date signed 4-28-44

G 16902 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

G 16902
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Fawcett (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin M. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1943

8. AGE: Years | Months: 4 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Charles B. Jones
13. Birthplace: Md. P. Young Lung

MOTHER
14. Maiden Name: Jessie
15. Birthplace: Md.

16 (a) Informant: Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Riderwood, Md.

18 (a) Funeral director: Lehmpuett & Duncan
(b) Address: 2615-17 Chestnut Ave.

19 (a) MAY 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19, at 1.0 30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Status thymico-lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gerstner M.D.
Medical Examiner.
Date signed May 5, 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16903 79534 G 16903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. G. H. 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Bank Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 5 hr. 30 min.

9. Birthplace West Baltimore General Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Luther Clark
13. Birthplace Johnstown Penna

MOTHER
14. Maiden Name Gernadine Kinin
15. Birthplace Johnstown Penna

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location UNIVERSITY MEDICAL SCHOOL MAY 5 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 5 1944 Huntington Williams M.D.
(Date rec'd by reg'r) (Registrar)

VS 180

F 0930

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to April 24 1944, and that I last saw him alive on April 25 1944.

	Duration
Immediate cause of death: Prematurity	
Due to: Pulmonary Atelectasis	
Due to: Bilateral.	5½ hr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Gertman, M.D.
Address 901 Fawcett Ave. Date signed 4/25/44

C 16904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

G 16904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-9-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3421 Keswick Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Justice
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife —
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) June 5-1888

8. AGE: Years	Months	Days	If less than one day
55	10	29	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Cement Foreman
11. Industry or business

FATHER
12. Name Charles F. Justice
13. Birthplace Maryland

MOTHER
14. Maiden Name Alberta Tilly
15. Birthplace Maryland

16 (a) Informant Mrs. Bertha Justice
(b) Address 1079 Orland Heights Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Co. Md
18 (a) Funeral director Durgin Funeral Home
(b) Address 3431 Falls Road
19 (a) MAY 5 1944 (Date received by registrar) (b) Hunter for Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4- 1944, at 6 45 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured 5-6 ?. Cervical vertebrae
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-4-44 at 6 A M.
(b) Where did injury occur? 3421 Keswick Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall down flight of inside stairs

23. Signature Howard J. Leberger M.D.
Medical Examiner.
Date signed 5-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 W. 37th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Latsford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 12-1875

8. AGE: Years	Months	Days	If less than one day
68	10	22	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation Carpenter J.H. University

11. Industry or business

FATHER 12. Name J. W. L. Latsford
13. Birthplace Baltimore Co. Md

MOTHER 14. Maiden Name Catherine Kildaride
15. Birthplace Baltimore

16 (a) Informant Frank R. Chalk
(b) Address 1214 W. 37th Street

17 (a) Burial (b) Date thereof May 6-1944
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory St. Mary's Hampden
Location Baltimore, Maryland

18 (a) Funeral director Dugan Funeral Home
(b) Address 3031 Falls Road

19 (a) (b)
Filed registrar
MAY 5 1944
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944, at 4:44 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1944, to May 4 1944, and that I last saw him alive on May 4 1944.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Hypertensive Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature William H. Lippitt M. D.
Address Union Memorial Hosp. Date signed 5/5/44

G 16906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16906

Registered No. 137a

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Kennedyville R.F.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country American

3 (a) FULL NAME Daniel M. Hill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Maryland (Town, County, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Hill
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Kilpatrick
15. Birthplace Maryland

16 (a) Informant Ella Hill
(b) Address Kennedyville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8/44 (month) (day) (year)
(c) Cemetery or crematory Stillwood md
Location Stillwood md

18 (a) Funeral director B.A. Fellows
(b) Address Still Pond

19 MAY 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1944 to May 4 1944 and that I last saw h~~im~~ alive on May 4 1944.

Immediate cause of death	Duration
Coronary Occlusion Pulmonary Embolus	
Due to	
Due to	
Other Conditions Advanced arteriosclerosis & hypertension (Include pregnancy within 3 months of death)	

Date of operation April 28, 1944

Major findings of operation: Enlarged prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John S. Haught M. D.
Address Redwood & Green Sts. Date signed 5/4/44

G 16907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G 16907 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 669 Fairmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Forrester
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/44

8. AGE: Years	Months	Days	If less than one day
			6 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Hilda Forrester
15. Birthplace

16 (a) Informant Hospital Admission Slip.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

MAY 5 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

UNIVERSITY MEDICAL SCHOOL MAY 5 1944 Commissioner of Health

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3 1944, to 5/3/ 1944, and that I last saw him alive on 5/3 1944.

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Prematurity	
Due to	
Other Conditions Fatal atelectasis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hosp. Date signed 5/5/44

0934

G 16908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G 16908

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Bruce Sts.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/44

8. AGE: Years 0 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Univ. Hosp. Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Odell Harris
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Gregory
15. Birthplace Virginia

16 (a) Informant Hospital Admission Slip
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 5 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 5 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

0933

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to May 2 1944, and that I last saw h[illegible] alive on May 2 1944.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions Subarachnoid Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hospital Date signed 5/5/44

G 16909 Baby Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered G 16909

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N. Carrollton
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Spencer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/25/44

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Lottie Woodson
15. Birthplace Virginia

16 (a) Informant Lottie Spencer
(b) Address 910 N. Carrollton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 5 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 5 1944 (b) Huntington Williams M.D.
If female, maiden name Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1944, at 9 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1944 to 4/26 1944, and that I last saw her alive on 4/26 1944.

Immediate cause of death	Duration
Possible cerebral hemorrhage	
Due to	
Due to	
Other Conditions Malnutrition, Prematurity	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Stewart M. D.
Address University Hospital Date signed 5/5/44

0932

C 16910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. C 16910

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 75 Dundalk Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Melvin Stange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1935

8. AGE: Years	Months	Days	If less than one day
8	7	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation School boy.

11. Industry or business

FATHER
12. Name Melvin W. Stange
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Melania Manivsky
15. Birthplace Austria.

16 (a) Informant Father
(b) Address 75 Dundalk Road, Baltimore

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore, Md.

18 (a) Funeral director J. A. Pfeiffer & Son
(b) Address Eastern Ave. & Lauraville Ave.

19 (a) 1944 (b) Huntington Williams, M.D. Registrar
(Date received by reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to May 4 1944, and that I last saw him alive on May 4 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Metastases from an abdominal neuroblastoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hurl Powerski
Address Union Mem'l Hosp Date signed 5/9/44

G 16911

30 187181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

147a

Registered No. G 16911

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Don't abbreviate except age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 3 da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 514 S. Clinton St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

F 98074

3 (a) FULL NAME Elizabeth Pazourek

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	215 03 4180

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1917

8. AGE: Years	Months	Days	If less than one day
26	9	22	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Frank E. Pazourek

13. Birthplace Maryland

MOTHER

14. Maiden Name Frances Gummer

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 6/44 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 403 S. WOLFE ST.

MAY 6 1944 (Date rec'd by registrar) Hamilton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1944 to May 2 1944 and that I last saw her alive on May 2 1944.

Immediate cause of death	Duration
Generalized Peritonitis due to Pelvic Abscess resulting	4 days
Due to Endometritis, Puerperal	
Due to	
Other Conditions Pyelitis	

(Include pregnancy within 3 months of death)

Date of operation April 30, 1944

Major findings of operation: Pelvic Abscess

of autopsy: Generalized Peritonitis

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. J. Sergeant M. D.

Address Baltimore City Hosp. Date signed 5/9/44

G 16912

G 16912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Carlin

(c) Hospital or institution: St Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County Baltimore

(c) City or town Overlea Parkville Th. Chesaco Park.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Edgewater Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Rhode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/1875

8. AGE: Years	Months	Days	If less than one day
68.	5	0	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Charles J. Horner

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Kevingander Krambert

15. Birthplace Balto Md.

16 (a) Informant Cecelia Zyboll

(b) Address Edgewater Ave & Chesaco Park Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Perry & Hill Rd.

18 (a) Funeral director Lally & Zeller Inc

(b) Address 901 E. Eaton Ave

19 (a) MAY 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1944, to 5-4 1944, and that I last saw h alive on 5-4 1944.

Immediate cause of death	Duration
Uremia	
Due to Sarcoma foot	
Due to Diabetis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-8-44

Major findings of operation: Amp. L. left leg

of autopsy: Not obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Helen J. Zawacki

Address St Joseph's Hospital Date signed 5/6/44 (M. D. Y.)

G 16913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

Registered No. G 16913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-D-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Carolina Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	~

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Iva Ferguson
(b) Address 610 N. Carolina St

17 (a) Burial (b) Date thereof 5 7 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn A.A. Co. Md

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 Jefferson St

19 (a) Washington Hill
(Date rec'd by local registrar)

MAY 6 - 1944

VS-461

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4- 1944, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 5-4-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16914
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md gene
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Elmer Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) apr. 15 '44

8. AGE: Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace Reisterstown Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William Jones
13. Birthplace Md

MOTHER — 14. Maiden Name gladys Pritt
15. Birthplace W. Va.

16 (a) Informant Thos. M. Jones
(b) Address Reisterstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant
Location Carroll Co

18 (a) Funeral director J. F. Eline & Sons
(b) Address Reisterstown Md

(a) Date received (b) Huntington Williams, M.D. (Registrar) Registrar

MAY 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5 1944, at 6.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1944, to 5-5 1944, and that I last saw him alive on 5-5 1944

Immediate cause of death: Terminal pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22, If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Seagrave M. D.

Address Md. Reisterstown Date signed 5/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 16915
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James N. Higgins

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Helen L. Higgins
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec 11th 1872

8. AGE: Years	Months	Days	If less than one day
71	4	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Foreman
11. Industry or business Standard Oil Co.

FATHER
12. Name James N. Higgins
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Whiten
15. Birthplace Unknown

16 (a) Informant Helen L. Higgins
(b) Address 1714 E. 30th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director William Bok Inc
(b) Address 1217 St. Paul St

(Date received by Registrar) MAY 6 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1944, at 2A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 27 1944, to May 4 1944, and that I last saw him alive on May 3 1944

Immediate cause of death: Pulmonary Interstinal Tuberculosis — Duration: years

Due to:

Due to:

Other Conditions Arteriosclerosis — Duration: years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm A Luetcher M. D.
Address 1 E Eager St Date signed May 4/44

G 16916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16916
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1158 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1158 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Holt

3 (b) If veteran, name war W
3 (c) Social Security Account No. 213-09-4709

4. Sex Male
5. Color or race White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed
6 (b) Name of ~~husband or~~ wife Anna Holt
6 (c) If alive, give age + years
7. Birth date of deceased (mo., day, yr.) abt 1877
8. AGE: Years About 66 67 | Months | Days | If less than one day hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Hub Dept Store

FATHER 12. Name Holt
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant William Rusk
(b) Address 1158 Washington Blvd
17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 MAY 6 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1944 at 8:30 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1943 to 5-3 1944, and that I last saw h[illegible] alive on 5/3 1944.

Immediate cause of death: Acute Cardiac Failure — Duration: 1 da
Due to Chronic Myocarditis — 2 yrs
Due to Arthritis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph E Lankaitis M. D.
Address 1158 Washington Blvd Date signed 5/5/44
Lankaitis

16917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C 16917

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 & 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. P. Snyder

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife: Sophia D. Snyder
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov 3rd 1859

8. AGE: Years	Months	Days	If less than one day
84	5 6	2	hr. min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Elevator Operator

FATHER
12. Name: Unknown Snyder
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Sophia D. Snyder
(b) Address: 1736 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) (Date received by local registrar) (b) Registrar

MAY 6 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1944, at 6A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/2/44 19 to 5/5/44 19, and that I last saw ~~him~~ alive on 5/5/44 19

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral hemorrhage

Due to: Hypertension

Other Conditions: Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: J. Abrahey MD
Address: 601 N. Monroe Date signed: 5/5/44 (M) (D)

16918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. C 16918

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Vermont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Vermont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA MILLER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1865

8. AGE: Years 79 | Months 3 | Days 14 | If less than one day: hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles W. Miller
13. Birthplace Weimar Saxony, Germany

MOTHER
14. Maiden Name Margaret Klatte
15. Birthplace Hanover, Germany

16 (a) Informant Dr. Chas. A. A. J. Miller
(b) Address 4210 Vermont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 6 - 1944 (b) Registrar

VS 160

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 5, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1944 to 5/5 1944 and that I last saw h[illegible] alive on 5/2 1944

Immediate cause of death: Coronary Thrombosis — Duration: Indefinite

Due to: Cardio-Vascular Disease Unknown

Due to:

Other Conditions: Senile
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Fredrick Ave. Date signed

16919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered 16919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th. St
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3 22 3 yrs 3 mos 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th. St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. John George Schmeltzer
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18. 1870

8. AGE: Years	Months	Days	If less than one day
74	3	16	hr. min.

9. Birthplace Charleston S.C (Town, county, and state)
10. Usual Occupation Dental Surgeon
11. Industry or business

FATHER
12. Name George Charles Schmeltzer
13. Birthplace Charleston S.C

MOTHER
14. Maiden Name Rebecca Mabus
15. Birthplace Columbia S.C

16 (a) Informant H. LeRue Browning
(b) Address 700 W. 40th. St Private

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. Md.

19 (a) MAY 6 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1941, to 5/4 1944, and that I last saw him alive on 5/4 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 Hours
Due to: Left Hemiplegia	4 Years
Due to: Arteriosclerosis (Hard)	
Due to: Hypertension - Essential Benign	13 Years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grafton Hesperger M.D.
Address 214 Medical Arts Bldg signed 5/4/44

G 16920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3428 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Mechlinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Angela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1908

8. AGE: Years	Months	Days	If less than one day
35	7	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Adam Mechlinski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Antonet Setara
15. Birthplace Baltimore

16 (a) Informant Angela Mechlinski
(b) Address 3428 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Orzechowski
(b) Address 1930 Eastern Ave Huntingdon Woodlawn, Md.

19 MAY 6 1944 (b) Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 19 , at 2 20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Fraham M.D.
Medical Examiner.
Date signed May 5, 1944

16921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16921 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 656 N. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Radawich (RADZEVICH)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Mary Radawich
(b) Address 656 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 44 (month) (day) (year)
(c) Cemetery or crematory St Mary Mtns Cem
Location

18 (a) Funeral director Joseph Kaminskas
(b) Address 605 Washington Blvd

19 (a) MAY 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944, at 9A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature J. J. Wollenweber M.D. (Medical Examiner.)
Date signed May 3, 1944

VS 151

PLEASE WRITE PLAINLY, with INDELIBLE INK. Every item of information should be given as correctly as possible. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 16922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 16922 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 S. Green
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S. Green St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura B. Saunders

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60 5-9	—		hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business at Home

FATHER
12. Name Victor Saucy
13. Birthplace md

MOTHER
14. Maiden Name Minta Heath
15. Birthplace md

16 (a) Informant Richard Saunders
(b) Address 602 S. Green

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7-44 (month) (day) (year)
(c) Cemetery or crematory Robinson Chapel Cem.
Location Granniville, md

18 (a) Funeral director James A Stagg
(b) Address 1142 W Hoffe St

MAY 6 - 1944 (Date rec'd) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 1944, at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to May 4 1944, and that I last saw h. e alive on May 3 1944.

Immediate cause of death	Duration
Chronic Cardio Vascular Renal disease	1 year
Due to Lung plegia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Jackson M. D.
Address 600 Washington Blvd signed 5/5/44

G 16923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 16923

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1222 Bayard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Bayard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred N. Skiles

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
77	-	—	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary —
15. Birthplace Unknown

16 (a) Informant Sarah Parker
(b) Address 1222 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location a-a. co. Md

18 (a) Funeral director James A Hayes
(b) Address 142 W. Lexington St

19 (a) MAY 6 - 1944 (Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944, at 10.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 15 1944 to May 4 1944; and that I last saw him alive on May 4 1944

Immediate cause of death	Duration
Odema of Lungs	2 day
Due to Hemiplegia Rt	week
Due to Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature M. L. Lichtenberg
Address VVV Madison ave Date signed 5/5/44

G 16924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16924 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 E. 41st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 E. 41st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN HAMLIN McKINDLESS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Viola McKindless
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 15, 1873

8. AGE: Years 71 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace: Penna.
(Town, county, and state)
10. Usual Occupation: Lawyer
11. Industry or business: Self

FATHER
12. Name: Alfred McKindless
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Elizabeth Hebb
15. Birthplace: Antietam, Va.

16 (a) Informant: Mrs. Ida V. McKindless
(b) Address: 700 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Signature of registrar) (b) Filed MAY 6 - 1944 Wilmer L. Wilson, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 4, 1944, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1942, to May 1 1944, and that I last saw h[illegible] alive on May 1 1944

	Duration
Immediate cause of death: Coronary thrombosis	1 day
Due to: Cerebral hemorrhage	18 Mos
Due to: Cardio-renal failure	12 Mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Frederick Lantz M.D.
Address Temple Garden Apt Date signed 5/5-44

G 16925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16925 Registered No. 134a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Towson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Sjoblom

3 (b) If veteran, name war C

3 (c) Social Security Account No. 218-07-7331

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	M.

6 (b) Name of husband or wife Fredericka Sjoblom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1871

8. AGE: Years	Months	Days	If less than one day
72 73	11	27 3	hr. min.

9. Birthplace Sweden (Town, county, and state)
10. Usual Occupation Ship Rigger
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Fredericka Sjoblom
(b) Address 1424 Towson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6th 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill.
(b) Address 1501 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) MAY 6 - 1944 Reg.

VS MAY 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1944 to 5-4 1944 and that I last saw h.. alive on 5-4 1944

Immediate cause of death	Duration
Uremia	
(a) Nitri-ite	
Due to Ulcerating tumor of G. U. tract	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry A. Brill M. D.
Address Univ. Hospt Date signed 5-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important.

G 16926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G 16926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Retz

3 (b) If veteran, name war —
3 (c) Social Security Account No. 220-05-8581

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Michael Retz
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): Sept 24th 1874

8. AGE: Years 69 | Months 7 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation: Canner
11. Industry or business

FATHER
12. Name: Emil Gatzke
13. Birthplace: Poland

MOTHER
14. Maiden Name: Wilhelming Herbe
15. Birthplace: Germany

16 (a) Informant: Mrs. John Baumann
(b) Address: 629 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6th 1944 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Annapolis Md.

18 (a) Funeral director: Charles F. Dill
(b) Address: 1501 E. Fort Ave.

19 (a) MAY 6 - 1944 (Date received by registrar) Registrar

VS 150

MAY 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to May 3 1944, and that I last saw h alive on May 2 1944.

Immediate cause of death: Tuberculosis and General Debilitation due to Progressive weakness from a Septic gall bladder condition (Empyema & gall bladder)

Duration: 4 mo

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: Dec 1943
Major findings of operation: Empyema & gall bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. J. Barranco M. D.
Address: 43 6 E. Fort Date signed 4/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

16927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 16927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2539 E.Biddle St.
(c) Hospital or institution:

8-13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 E.Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Steven V.Hitzelberger Sr.

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary H.Hitzelberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr.5,1891

8. AGE: Years	Months	Days	If less than one day
53	0	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Hitzelberger
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah ---
15. Birthplace Md.

16 (a) Informant Mrs.Mary H.Hitzelberger
(b) Address 2539 E.Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.Park
Location

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 MAY 6 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4/44 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 19XX to May 4 19XX and that I last saw him alive on May 3 19XX.

Immediate cause of death: Valvular Heart disease — Duration: 6 Mos
Due to: Chronic Nephritis — 2 yrs
Due to:
Other Conditions: Bronchitis Chronic

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Fisher M. D.
Address 1823 N. Wash St. Date signed 4/5/44

G 16928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16928
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inserted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Hunter St.
(c) Hospital or institution: Balto., Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Hunter St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Preston

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Negro	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 2-10-64

8. AGE: Years	Months	Days	If less than one day
80	2	24	___ hr. ___ min.

9. Birthplace Hartford Co., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Miranda Jones
(b) Address 2209 Hunter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto., Md.

18 (a) Funeral director Charles R. Law
(b) Address 902 Madison Ave.

19 MAY 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4-44 19___, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 25, 1944 to May 4, 1944 and that I last saw ___ alive on May 4, 1944

Immediate cause of death	Duration
Hypertension Cardio Renal Disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice Otten, M.D.
Address 312 E. 23rd St Date signed 5/6/44

VS 8

G 16929

16929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution:
Church Home & Hospital 6 - 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 E. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Goon (GEORGE GOON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Chinese	Married

6 (b) Name of husband or wife Lee Toi Sum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1875

8. AGE: Years	Months	Days	If less than one day
68	8	0	hr. min.

9. Birthplace California (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hue Goon
13. Birthplace China

MOTHER
14. Maiden Name Yee See
15. Birthplace China

16 (a) Informant Hospital Records (Archey Wong)
(b) Address 203 W Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 41 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn.

18 (a) Funeral director Sherwood Morgan Co.
(b) Address 108 W Mt Royal Ave

19 (a) (Date received) (Registrar) Huntington Williamsport, Md.

MAY 6 1941
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 41, at 1:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 19 41 to 5/5 19 41, and that I last saw h.m. alive on 5/5 19 41

Immediate cause of death Cardiac Failure — Duration ?
Uremia — 4 days ?
Due to Arteriosclerotic H. D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S A Gretsky M. D.
Address Church Home & Hosp. Date signed 5/5/41

16930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V137a

Registered No. C 16930

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied, write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital - 1951
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 W. Carey St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac LaKeman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 12-25-1895
8. AGE: Years 48 Months 4 Days 6 If less than one day ... hr. ... min.
9. Birthplace — (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business —

FATHER
12. Name ?
13. Birthplace B. W. I.

MOTHER
14. Maiden Name Deborah
15. Birthplace B.W.I.

16 (a) Informant Cliz Thomas (O.F.)
(b) Address 404 N. Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.
18 (a) Funeral director Chas Harper
(b) Address 512 Carrollton Ave.
19 (a) (Signature) (b) Date received

MAY 6 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at 6:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/1944, to 5/3 1944, and that I last saw h.i.m. alive on 5/3 1944.

Immediate cause of death	Duration
1 Uremia	
Due to 2 Prostatic Hypertrophy	
Due to 2 Hydronephrosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy (a) Benign Prostatic Hypertrophy, (b) Hydronephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. V. Palmer
Address University Hospital Date signed 5/3/44 M. D.

Dr Edward Benson 1W. Oxford Ave Hamp 1240

16931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 16931

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5415 Summerfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5415 Summerfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Schimpf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married,~~ widowed, or divorced: Widowed

6 (b) Name of husband Frederick John Schimpf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5th 1873

8. AGE: Years 70 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER: 12. Name Ecoff

FATHER: 13. Birthplace Harford Co.

MOTHER: 14. Maiden Name

MOTHER: 15. Birthplace

16 (a) Informant Frederick Schimpf

(b) Address 5415 Summerfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Maryland Park

Location Parkville, Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st.

19 (a) [illegible] (b) Huntington Williams, M.D.

MAY 6 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1944, 11 35 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1941 to May 4th 1944, and that I last saw her alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arterio Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. H. Benson

Address 1 W. Oxford Ave Date signed 5/5/44 M. D.

EDW. H. BENSON

G 16932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80 b

Registered No. G 16932

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7. Calvert Street

(c) Hospital or institution: Mercy Hospital 4-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County Baltimore

(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)

(d) Street No. Sudbrook Road. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Stevens Susemihl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jack B. Susemihl

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 12/24/16

8. AGE: Years 27 | Months 4 | Days 12 | If less than one day — hr. — min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

MOTHER / FATHER

12. Name Ray Powell

13. Birthplace North Carolina

14. Maiden Name Dorthy Simmons

15. Birthplace North Carolina

16 (a) Informant Jack B. Susemihl

(b) Address Sudbrook Rd. - Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery

Location Pikesville, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

MAY 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/44 19 44, at 12 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 19 44, to 5/5 19 44, and that I last saw her alive on 5/6 19 44

Immediate cause of death Cardio-Respiratory Failure — Duration 6 wks.

Due to Bulbar Palsy — Duration Unknown

Due to Encephalitis (Virus) or Brain Tumor

Other Conditions (over)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirming

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert B. McFadden M.D.

Address Mercy Hospital Date signed 5/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

16933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G 16933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3626 Bayonne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3626 Bayonne (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laurie A. Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 20 1897

8. AGE: Years: 51 | Months: 9 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: J. Thomas Buck
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Jenny Jones
15. Birthplace: Balto.

16 (a) Informant: Mr. John E. Turner
(b) Address: 3626 Bayonne

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 5-8-44 (month) (day) (year)
(c) Cemetery or crematory: Moreland P.K. Cemetery
Location: Balto

18 (a) Funeral director: Leonard H. Buck
(b) Address: 1305 Harford Road

19 (a) Filed MAY 6 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at 9:7 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to May 1 1944, and that I last saw h[illegible] alive on May 1 1944.

Immediate cause of death: Pulmonary Edema.
Due to: Squamous Cell Carcinoma, Right Breast.
Due to: Liver Metastasis.
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William C. Rapp M. D.
Address 1138 Maunsell St. Date signed 5/5/44.

occ.

16934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. 16934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 WISE COURT 26
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Wise Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Adelmann.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife MARY ADELMANN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 1868

8. AGE: Years 76 Months 81 Days 3 If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name MICHAEL ADELMANN
13. Birthplace GERMANY

MOTHER
14. Maiden Name KATHERINE ?
15. Birthplace GERMANY

16 (a) Informant JAMES J. FROWLEY (NEPHEW)
(b) Address 713 S. ROSE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 8/44 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lilly and Geiler, INC.
(b) Address 403 S. WOLFE ST.

19 MAY 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Amputation of legs.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6 P.
(a) Date of injury May 4, 1944 10:45 M.
(b) Where did injury occur? P.R.R. Bantam & Chester Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public Place While at work? No
(d) Means of injury Struck by Locomotive

23. Signature Robert Lee Fraker M.D.
Medical Examiner.

Date signed 5-5-44

VS 151

G 16935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 16935

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton and Wilkins Sts.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Evansville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Harvey

3 (b) If veteran, name war: World War - No 1

3 (c) Social Security Account No. 207-03-0225

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Harvey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1894

8. AGE: Years 50 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER 12. Name John Harvey

13. Birthplace Pa.

MOTHER 14. Maiden Name Katherine Hoffer

15. Birthplace Pa

16 (a) Informant Chas. Harvey

(b) Address Pa. (Evansville)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)

(c) Cemetery or crematory Family Lot

Location Ebenezer Pa

18 (a) Funeral director Edw. J. McGrath

(b) Address Catonsville - Md

(c) (Date received) MAY 7 - 1944 (Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/ 19 44, at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 19 44, to 5/5 19 44, and that I last saw h[illegible] alive on 5/5 19 44.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Arthur Fossard

Address St. Agnes Hosp. Date signed 5/8/44

G 16936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16936 Registered No. 91a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairfield & Green
(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town New Castle Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hopkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Florence Elizabeth Hopkins
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) August 24, 1886

8. AGE: Years	Months	Days	If less than one day
57	8	12	hr. min.

9. Birthplace New Castle Co. Delaware (Town, county, and state)
10. Usual Occupation Farming
11. Industry or business

FATHER
12. Name James Henry Hopkins
13. Birthplace Sussex Co. Delaware

MOTHER
14. Maiden Name Katherine Thomas
15. Birthplace Philadelphia Pa.

16 (a) Informant Mrs Florence Elizabeth Hopkins
(b) Address Elkton, Md Route 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1944 (month) (day) (year)
(c) Cemetery or crematory New Castle Co
Location Delaware

18 (a) Funeral director Chandler H. Gebhart
(b) Address New Castle Del.

MAY 7 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-44 19..., to 5-6 1944, and that I last saw h... alive on 5-6 1944.

Immediate cause of death	Duration
Cerebral Embolism	
Due to acute Bacterial Endocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley M.D.
Address University Hospital Date signed 5/6/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 16937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1639

G 16937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HAZEL EDNA SHARPE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Kenneth Sharpe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5. 1906

8. AGE: Years 38 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Jefferson Co. N.Y.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Haskins
13. Birthplace New York

MOTHER
14. Maiden Name Mary
15. Birthplace New York

16 (a) Informant Benjamin B. Sharpe
(b) Address Carthage, N.Y.

17 (a) Removal (b) Date thereof May 6-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Potsdam, New York

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Fpells Road

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 7 1944

VS 15-C 44

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1944 at 5 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sodium fluoride poisoning

Suicide!

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-29-44 at 11 a M.
(b) Where did injury occur? at home address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury took sodium fluoride by mouth

23. Signature H. Z. Wallenmeyer M.D.
Acting Medical Examiner.
Date signed 4-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 16938 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Percival W. Wilson

3 (b) If veteran, name war W
3 (c) Social Security Account No. 213-05-2455

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife Single If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/25/1880

8. AGE: Years	Months	Days	If less than one day
63	7	12	hr. min.

9. Birthplace Conn. (Town, county, and state)
10. Usual Occupation Carter
11. Industry or business Express

FATHER
12. Name Moses H. Wilson
13. Birthplace Long Island N.Y.

MOTHER
14. Maiden Name Rebecca Sammis
15. Birthplace Long Island N.Y.

16 (a) Informant Elizabeth Mackay
(b) Address 1921 Eutaw Place

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Huntington Rural
Location Huntington L. I.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul Place

19 (a) (Date received) MAY 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1944 at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1944 to 5/6 1944 and that I last saw h.i.m. alive on 5/6 1944.

Immediate cause of death	Duration
Carcinoma Respiratory Tract	
Due to Cardiac Decompensation	4 wks.
Due to Hypertensive C.V. Disease	Unknown
Other Conditions Pneumonia-Lobar	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature T. B. McFadyen M. D.
Address Mercy Hospital Date signed 5/6/44

G 16939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16939 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert St.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) (?)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore.
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3921 Canterbury Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Claiborne Latrobe.

3 (b) If veteran, name war: W.
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Aileen Latrobe
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.) 3/15/89

8. AGE: Years 55 | Months 1 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, MD. (Town, county, and state)
10. Usual Occupation Historical Research
11. Industry or business Self

FATHER
12. Name Ferdinand C. Latrobe.
13. Birthplace MD.

MOTHER
14. Maiden Name Ellen Swann
15. Birthplace MD.

16 (a) Informant wife.
(b) Address (see above)

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1417 St. Paul St

MAY 7 - 1944 (Date rec'd by registrar) Thomas J. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 1944, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1944 to 5/5 1944, and that I last saw him alive on 5/5 1944.

Immediate cause of death: cardiac failure. — Duration: 6 hrs.
Due to: myocardial infarct.
Due to: coronary sclerosis.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation: 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas L. Cliffell M. D.
Address Union Mem. Hosp. Date signed 5/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3834 Reist. Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Benjeman Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Motion Picture Owner (Town, county, and state) Ramsey North Carolina

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Pul Rel & Bowley Lane

18 (a) Funeral director Jack Lewis Sons
(b) Address 1439 E. Balto St.

19 (a) (Local registrar) (b) Baltimore, Md.

MAY 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/ 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26/1944 to 5/5/1944, and that I last saw him alive on 5/5/1944

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction	
Due to Coronary occlusion	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwards
Address Sinai Date signed 5/8/44

G 16941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16941 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 10
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? I (Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret Dennis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank Dennis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1865

8. AGE: Years 79 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name George Dennis
13. Birthplace Germany

MOTHER
14. Maiden Name Un Known
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Old Frederick Road

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 MAY 7 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944, at 6 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from APR 11 1944 to MAY - 4 1944, and that I last saw h. E. alive on MAY - 4 1944

Immediate cause of death General Edema and Broken Compensation — Duration 2 Days
Due to Myocarditis
Due to
Other Conditions X X X X

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: X X X
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X X X
(b) Date of occurrence X X at X X M
(c) Where did injury occur? X X X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X X (Specify type of place) While at work? X X
(e) Means of injury X X X

23. Signature O. H. Dukes M.D.
Address 928 E. North Ave Date signed 5/6/44

G 16942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16942 Registered No. 1318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Keelty (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Franklintown (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Dean

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Waterman

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8/44 (month) (day) (year)
(c) Cemetery or crematory Cambridge Cem
Location Cambridge Md

18 (a) Funeral director John W. Mitchell Sons
(b) Address 1960 Eutaw Place

19 (a) [illegible] (Filed by registrar) Huntington Williams, M.D.

MAY 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1944 at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3 1944 to 5/6 1944 and that I last saw h[illegible] alive on 5/4 1944.

Immediate cause of death	Duration
Myocardial failure	2 days
Due to Chronic myocarditis + chronic glomerulonephritis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.
Address St. Agnes Hosp Date signed 5/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16943

G 16943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 St. Paul St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Fletcher Williams, Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Anne McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1889

8. AGE: Years	Months	Days	If less than one day
54	4	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation salesman
11. Industry or business

FATHER
12. Name John Fletcher Williams
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden Name Lucy Jane Sanderson
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mr. Roger Williams
(b) Address 1604 First National Bank Bldg.

17 (a) Burial (b) Date thereof 5/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) Huntington Williams, M.D.
MAY 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944 at about 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1942 to May 4 1944 and that I last saw her alive on May 4 1944 at 7 a.m.

Immediate cause of death Coronary Occlusion Duration

Due to Arterio-Sclerosis

Due to

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Corbin Streett, M.D.
Address 712 Park Ave. Date signed May 7 1944

G 16944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 Brookfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Brookfield Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME AARON WALDORF

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1878

8. AGE: Years 65 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clothing Salesman
11. Industry or business

FATHER
12. Name Moses Waldorf,
13. Birthplace Germany.

MOTHER
14. Maiden Name Theresa Fuld,
15. Birthplace Germany.

16 (a) Informant Mr. Manes Waldorf,
(b) Address 2506 Brookfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1944. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levering Levy
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

MAY 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th. 1944, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944, to May 6, 1944.
and that I last saw h alive on May 5, 1944.

Immediate cause of death — Duration
Myocardial insufficiency — 1 week
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard L. Levy M.D.
Address 2322 Eutaw Place. Date signed 5/6/44

G 16945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 16945 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 N Smallwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 N Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zelda Finkelberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Zetzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Solomon Kaufman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fannie ?
15. Birthplace: Russia

16 (a) Informant: Fannye Cohen
(b) Address: 2026 N Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) MAY 7 1944 (Date) (b) [illegible] Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 10.45

20. DATE OF DEATH: May 6, 1944 at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1941, to May 6, 1944, and that I last saw her alive on May 6 1944

	Duration
Immediate cause of death: Pulmonary Edema	1 hr.
Due to: Cardiac Insufficiency, Cardiac Hypertrophy	4 years.
Due to: Hypertension	
Other Conditions: Multiple Cerebral Accidents. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Sheldon Cooper M. D.
Address 2107 Park Ave. Date signed 5/7/44

G 16946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16946 Registered No. 1600

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The entire age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 S. Buckfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Baby Girl Wint) Glenn F. Wint Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-3-44.

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Glenn F. Wint Sr.
13. Birthplace Md.

MOTHER 14. Maiden Name Emiley Jones
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 107 S. Buckfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Martin Zapf & Sons
(b) Address 1824 N. North Ave.

MAY 7 1944 (Date) registered Huntington Williams M.D.

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/44 19 at 6:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3/44 19 to 5/6/44 19; and that I last saw h[illegible] alive on 5/6/44 19

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral damage following delivery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary J. Bryan
Address St Agnes Hosp Date signed 5/6/44

G 16947 BALTIMORE CITY HEALTH DEPARTMENT G 16947
CERTIFICATE OF DEATH V 13 a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Bedside
(b) Street address 1823 E. Eutaw St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 E. Eutaw St.
(If rural, give R.F.D. number)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Weatherspoon (name?)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 21, 1898
8. AGE: Years 45 | Months 10 | Days 14 | If less than one day hr. min.
9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Childe Buchanan
FATHER 13. Birthplace N. C.
MOTHER 14. Maiden Name Florence ?
MOTHER 15. Birthplace N. C.
16 (a) Informant Elizabeth [illegible] 1823 E. Eutaw St.
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.
18 (a) Funeral director W. Pabst Kirk & Elliott Dgt.
(b) Address 112 N. Caroline St.
19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar
MAY 7 1944 VS

MEDICAL CERTIFICATION
20. DATE OF DEATH April 5th 1944 at 4 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1944 to 5-5 1944 and that I last saw h[illegible] alive on 5-4 1944
Immediate cause of death: Hypertensive cardio-renal disease. — Duration: unk.
Due to:
Due to:
Other Conditions: enlarged aorta
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Rayner Browne
Address 130 W. Madison St. Date signed 5/6 M.D.

Rayner Browne

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (46)

G 16948 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Low St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Low St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Venable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) February 9, 1899

8. AGE: Years	Months	Days	If less than one day
45	2	26	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Monroe
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Frank Venable
(b) Address 1126 Low St.

17 (a) Burial (b) Date thereof May 8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location O. G. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Carolina St.

(a) Date received by registrar MAY 7 - 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25- 1944, to 5-5- 1944, and that I last saw h.er alive on 4-30- 1944

Immediate cause of death: Carcinoma of the rectum — Duration: Unknown

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Cargill M. D.
Address 611 N. Carolina Date signed 5-6-44

W. H. CARGILL

G 16949

G 16949

453694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5651 Govane Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Jacob Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-17-81

8. AGE: Years	Months	Days	If less than one day
63	7	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Lineman

11. Industry or business Electricity

FATHER
12. Name Clarence Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Woodfield
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-1944 (month), (day), (year)
(c) Cemetery or crematory Prospect Hill Cemetery
Location

18 (a) Funeral director Mary M Rudefeld
(b) Address 501 E. 22nd St. Huntington Williams, M.D.

19 (a) (Approved by Registrar) (b) Registrar

MAY 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944 at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1944 to May 5 1944, and that I last saw him alive on May 5 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Lobar pneumonia RLL, LLL, Type 7	
Due to 4th day	
Other Conditions cirrhosis arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anatomical Diag. 5/7/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Conacin
Address J.C.H. Date signed 5-M-D

G 16950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 16950 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 Whitridge Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 Whitridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. Mullin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 60 Months — Days — If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Shipper

11. Industry or business

FATHER
12. Name Patrick Mullin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A Ruane
15. Birthplace Ireland

16 (a) Informant J. Mullin
(b) Address 317 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 20 E. Lexington St

19 (a) (Signature of registrar) Huntington Willis, M.D.

MAY 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1944 to May 5 1944, and that I last saw h.im alive on May 3 1944.

Immediate cause of death: Carcinoma of oesophagus — Duration: 3 Mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Hartman Jr M. D.
Address 2796 St Paul Date signed 5/6/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G 16951 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 E. 33rd. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. 33rd St. Apt. 3B. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Newcomber Heggan

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Heggan

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1866

8. AGE: Years 77 | Months 4 | Days 11/12 | If less than one day: hr. min.

9. Birthplace Hagerstown Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Retired

FATHER 12. Name Jonathan Newcomber

13. Birthplace Maryland

MOTHER 14. Maiden Name Ann Catherine Adams

15. Birthplace Maryland

16 (a) Informant Miss Mary K. Heggan

(b) Address 10 E. 33rd St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10, 1944 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cem.

Location Hagerstown, Md.

18 (a) Funeral director Andrew Kaufman

(b) Address Hagerstown, Md.

19 (a) MAY 7 1944 registrar [illegible] Baltimore, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1943, to May 6 1944, and that I last saw h[illegible] alive on May 6 1944

Immediate cause of death: Coronary Thrombosis — Duration: Unknown

Due to: Arteriosclerosis — Duration: Unknown

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos. R. Goldsborough M. D.

Address 2923 St Paul St Date signed 5/7/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 16952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16952

Ground Floor - Mrs. Lippard
Ground - 727 Chemical B. & Co.

Every item of information should be typewritten or written with pen and ink. Do not use pencil. Do not use any abbreviations. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga (b) County.....
(c) City or town Camilla
(If outside city or town limits, write RURAL and give town)
(d) Street No. 231 Lincoln Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Jester Jr.

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 21 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER — 12. Name Robert L. Jester Sr.
13. Birthplace.....

MOTHER — 14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a) Removal (b) Date thereof ..... (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Camquille, Ga

18 (a) Funeral director Elmer E. Bullock
(b) Address 556 Lewis St. Harvard Place

19 (a) ..... (b) Huntington Williams M.D.
(Date received by registrar)

MAY 7 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 6 - 1944, at ..... M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Acute Pulmonary Edema
Acute Congestive Cardiac Failure
Due to.....
Stab wounds of abdomen
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-6-44 at 1A M.
(b) Where did injury occur? Whitelock & Nelson A.S.W.Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 5-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 16953

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Kirk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Kirk Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Carville Bevans

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie M. Bevans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1868

8. AGE: Years	Months	Days	If less than one day
75	9	14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name John C. Bevans
13. Birthplace Unknown

MOTHER
14. Maiden Name Katherine Dixon
15. Birthplace Wilmington N.C.

16 (a) Informant Nellie T.C. Grimm (Daughter)
(b) Address 2905 Kirk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry C. Armacost
(b) Address 4204 Ridgewood Ave

19 (a) MAY 8 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944, to May 5 1944, and that I last saw h[illegible] alive on May 5 1944.

Immediate cause of death	Duration
Broncho Pneumonia	3 d.
Empyema Bronchi	5 d.
Due to Malignant Neoplasm Vocal Cord	1 mo.
Arteriosclerosis	1 mo
Due to Aneurism Pectoris	1 mo
Other Conditions Chr. Interstitial Nephritis	1 mo

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira Stearns M. D.
Address 2878 Sanford Rd Date signed 5-6-44

G 16954

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 N Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Esther Parr

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 18, 1907

8. AGE: Years 36 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER: 12. Name Frank E. Bassuick
13. Birthplace Md.

MOTHER: 14. Maiden Name Elizabeth Kibby
15. Birthplace Md.

16 (a) Informant Mrs. Parr.
(b) Address 2700 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

(a) (b)

MAY 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 19 44 to 5/9 19 44
and that I last saw her alive on 5/7 19 44

Immediate cause of death Pneumococcic peritonitis — Duration 2 wks

Due to

Due to

Other Conditions Toxic Hypothesis 1 wk

(Include pregnancy within 3 months of death)

Date of operation 4/28/44

Major findings of operation: Pneumococcal peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Jane Polley M. D.
Address Date signed

G 16955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G 16955

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens and Caton Aves.

(c) Hospital or institution:

St. Agnes

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 331 S. Ellamont St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lawrence G. Nelson

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 9th 13

8. AGE: Years | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Francis (Dec'd)

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Jean Lebrieat

15. Birthplace New York

16 (a) Informant Jean Nelson

(b) Address 331 S. Ellamont St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/9/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Carmel

Location Balto Md

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (a) ~~Signature of~~ Registrar Washington Williams M.D.

(Date received by registrar) MAY 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7/44 19 , at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5/44, to 5/7/44 19, and that I last saw her alive on 5/7/44 19

Immediate cause of death	Duration
Respiratory failure	
Due to Acute Lobar Pneumonia	
Due to Delivery at home	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryan M. D.

Address St Agnes Hosp Date signed 5/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 16956 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Lauretta Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Wirts

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1866

8. AGE: Years 77 | Months 10 | Days 5 | If less than one day hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER
12. Name Benjamin Wirts
13. Birthplace Baltimore Md
14. Maiden Name Laura Lancaster
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Bertha Bishop
(b) Address 2309 Lauretta Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
(c) Huntington Williams, M.D. (Registrar) Registrar

MAY 8 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1944, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 1944, to 5/7 1944, and that I last saw ~~him~~ alive on 5/7 1944.

Immediate cause of death Card.-Resp. Failure — Duration 7

Due to Carcinoma of the Esophagus & metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. N. Crosley
Address Mercy Hosp. Date signed 5/7/44

G 16957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16957 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 S. Ann Street
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 S. Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Owens (Maddox)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or ~~wife~~: Joseph Frank Owens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1888

8. AGE: Years	Months	Days	If less than one day
55	11	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name (Unknown) Norton
13. Birthplace Md.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Margaret Maddox
(b) Address 339 S. Ann St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Marys
Location Hampden (Local)

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Filed (month) (day) (year) (b) Huntington Williams, M.D. Registrar

MAY 8 1944

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1944, at 1:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. D. Z. Wollenweber M.D. Medical Examiner.
Date signed May 6, 1944

G 16958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16958

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, ~~Maryland~~
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Street No. [illegible] (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4624 Northwood Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Raidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Albert W. Raidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29th 1888

8. AGE: Years 55 | Months 11 | Days 6 8 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Michael Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Germany

16 (a) Informant Edward M. Raidt
(b) Address 4624 Northwood Drive

17 (a) Burial (b) Date thereof 5/9/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 W. Pratt St.

MAY 8 - 1944
(a) (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1944, at 3.20 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenhorst M.D.
Medical Examiner.
Date signed May 6, 1944.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16959
AB-67301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 13B

G 16959
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Moore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brooks or Richard Brooks Scroggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16- 1920

8. AGE: Years	Months	Days	If less than one day
24	3	18 17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Richard Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Barber Johnson (D)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 631 Druid Hill Ave.

MAY 8 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1944, to 5/5 1944, and that I last saw h[illegible] alive on 5/5 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattne M.D.
Address B.C.H. Date signed 5/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16960 — 71775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

G 16960 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs-2mos-21days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5220 Pennington Ave., Curtis Bay (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: George Franklin

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ilene (D)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15 1871

8. AGE: Years 72 | Months 6 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER — 12. Name: George Franklin
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Elizabeth Robinson
15. Birthplace: Md.

16 (a) Informant: Baltimore City Hospitals
(b) Address: Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: A. A. Co., Md.

18 (a) Funeral director: Isaac L. Brantley
(b) Address: 108 W Montgomery St

19 (a) MAY 8 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1944, at 3.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/1 1944 and that I last saw h[illegible] alive on 5/1 1944

Immediate cause of death: Intestinal obstruction (?) ileus. definitely established — Duration: 24 hr. (?)

Due to: Inguinal hernia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. L. Seymour M.D.

Address: BCH Date signed 5/4

G 16961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

G 16961
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N. CURLEY St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Spicer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Anna Spicer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 14-1876

8. AGE: Years	Months	Days	If less than one day
67	11	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Tally Man
11. Industry or business P.R.R.

FATHER
12. Name Spicer
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant John C. Spicer
(b) Address 531 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/44 (month) (day) (year)
(c) Cemetery or crematory Schwartz's Cem.
Location O. Donnell St.

18 (a) Funeral director John G. Miller
(b) Address 2534 Jefferson St.
(c) Date rec'd by registrar MAY 8 - 1944 Signature of registrar Wellington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH (month) May (day) 5 (year) 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to May 5 1944, and that I last saw him alive on May 1 1944

Immediate cause of death	Duration
Coronary Occlusion	1 hour
Due to Chronic Myocarditis	10 yrs?
Due to Arteriosclerosis	10 yrs?
Other Conditions Cardiac Asthma.	10 yrs?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Michael J. Dausch
Address 2530 E. Baltimore St. Date signed 5/7/44

16962
Transcript

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 169

Registered No. C 16962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore. (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Dorsey
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Weisner [Edward H. Wiesner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23 - 1862

8. AGE: Years 82 | Months 2 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Hotel

11. Industry or business

FATHER
12. Name Weisner
13. Birthplace Germany

MOTHER
14. Maiden Name Edna N.
15. Birthplace Germany

16 (a) Informant My Stuart Yeatman
(b) Address 15 Guilford Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 5 - 8 - 44 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Dorsey Md

18 (a) Funeral director Harry H. Wirth
(b) Address 4101 Edmondson Ave

19 MAY 8 - 1944 (Date received by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1944, at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-5-44 at 12:10 P.M. a.a.tor.
(b) Where did injury occur? Train Station, Dorsey, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury struck by train under [illegible] tracks from N. side

23. Signature J. J. Wollenweber M.D.
Medical Examiner.

19 Date signed May 6, 1944.

G 16963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 16963

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Biddle & Fairmount Ave.

(c) Hospital or institution: Church Home & Hosp 1664

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 714 N. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Mary L. Holmes

3 (b) If veteran, name war none

3 (c) Social Security Account No. 0

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. L. Holmes Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1861

8. AGE: Years 83 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER

12. Name Frederick Roskamp

13. Birthplace Germany

MOTHER

14. Maiden Name Luzetta Schuth

15. Birthplace Germany

16 (a) Informant Maurice Holmes

(b) Address 1709 Eutaw St., Balto.

17 (a) Buried (Burial, cremation, or removal)

(b) Date thereof 5 | 9 | 44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director Geo. Weber & Son

(b) Address 2503 Edmondson Ave (Huntington Pallisades, Md.)

19 (a) (Registrar) Registrar

(b) Date received MAY 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1944, at 7:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1944 to May 6 1944, and that I last saw h.. alive on May 6 1944.

Immediate cause of death: Pulmonary Embolism

Duration

Due to

Due to

Other Conditions atelectasis of right lower lobe

Operation: Yes or No; if pregnancy, months

Date of operation 5/3/44

Major findings of operation: inter-trochanteric fracture of neck of left femur

If autopsy: pulmonary embolism

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/4

(a) Accident, suicide, or homicide accident

(b) Date of occurrence May 2 1944 at 6 P.M.

(c) Where did injury occur? Baltimore, Balto., Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? home - work

(e) Means of injury fell down cellar steps

23. Signature Isabella Harrison M. D.

Address Church Home Hospital Date signed 5-6-44

To be taken to Medical Examiner's Office

G 16964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton aves

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Catonsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. Cherrydell

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Mary A. Goodrich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Richard Goodrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28-1876

8. AGE: Years	Months	Days	If less than one day
68	2	6	hr. min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name August Opel

13. Birthplace Md

MOTHER

14. Maiden Name Elizabeth Klein

15. Birthplace Balto Md

16 (a) Informant Miss Katherine Opel

(b) Address Cherrydell, Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo. K. Beyer Jr

(b) Address Hollins St.

19 MAY 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3 1944, to 5/4 1944, and that I last saw h.e alive on 5/4 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Arthur Rosberg M.D.

Address St. Agnes Hosp. Date signed 5/4/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 16965

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2856 E. Mulberry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Guy R. Coram

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-0958

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~ or divorced: Married

6 (b) Name of husband or wife Rose Coram

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb 12 - 1886

8. AGE: Years 59 | Months 2 | Days 22 24 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Aircraft, Gen'l Machine

FATHER 12. Name Joseph Coram

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Yoder

15. Birthplace Md

16 (a) Informant Hosp. Record.

(b) Address University Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Balto Md

18 (a) Funeral director Geo. H. Leinstad

(b) Address 525 N. Lynnhurst Ave

19 (a) MAY 8 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6- 1944, at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3- 1944 to 5-6- 1944 and that I last saw him alive on 5-6 1944

Immediate cause of death: Pulmonary Edema, Cerebral Accident — Duration

Due to Hypertension, Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank M. Shipley M. D.

Address University Hosp. Date signed 5-6-44

G 16966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 16966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Prentiss Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1882

8. AGE: Years 61 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Steward (Ship)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Arturo Pagano
(b) Address 720 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 8 44 (month) (day) (year)
(c) Cemetery or crematory Loyola Head Mary
Location Gernan Hill Rd

18 (a) Funeral director Geo. D. Kenny
(b) Address Holden & Guilford

19 (a) Date filed by Registrar MAY 8 - 1944 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1944, at 5:22 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 5-8-44

G 16967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 16967 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Bolton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie P. Olwine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John R. Olwine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 17, 1882

8. AGE: Years	Months	Days	If less than one day
62.		19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Thomas Collins
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Green
15. Birthplace Ireland

16 (a) Informant Mrs John R. Olwine
(b) Address 1719 Bolton Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/9/44 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location 1300 Woodland Ave
18 (a) Funeral director John J Cowan & Son
(b) Address 90403 Baltimore Nat'l Bank
19 (a) MAY 8 1944 Registrar

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1944 at 5 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 19YY to May 6 1944, and that I last saw alive on May 5 1944

Immediate cause of death Cerebral Hemorrhage — Duration 9 days

Due to Hypertension — Duration unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Ostrum M.D.
Address 1914 W North Ave Date signed 5/6/44

G 16968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16968 Registered No.

YA-86491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 E. Montgomery St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Theodore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1915

8. AGE: Years	Months	Days	If less than one day
28	5	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Edward Ebenhach
13. Birthplace ?

MOTHER
14. Maiden Name Bertha Laage
15. Birthplace Baltimore, Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 10 44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2524 Orleans St

19 [illegible] Eugene Williams [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1944, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1944, to 5-6 1944, and that I last saw h[illegible] alive on 5-6 1944

Immediate cause of death Pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Maltone M. D.

Address B.C.H. Date signed 5/6/44

G 16969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G 16969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Druid Hill Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Caldwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1903

8. AGE: Years 40 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Harlan County, Ky. (Town, county, and state)

10. Usual Occupation Steel erector

11. Industry or business

FATHER 12. Name Lawd W. Caldwell

13. Birthplace Pa.

MOTHER 14. Maiden Name Astelle Gullet

15. Birthplace Pa.

16 (a) Informant Louis Caldwell

(b) Address 1004 W. Washington

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 8, 1944 (month) (day) (year)

(c) Cemetery or crematory Ashland Cem.

Location Ashland, Ky.

18 (a) Funeral director Wm. F. Carroll Home

(b) Address 1008 Orleans St

(a) MAY 8 - 1944 (Date rec'd by registrar) Hunting for Williams, Mgr

VS 151

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 7, 1944, at 6 M

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured ribs, left Fractured left clavicle Contusion of chest (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/7/44 at 3:30 A.M. 25/6
(b) Where did injury occur? Bethlehem Hatfield Shipyard
(c) Did injury occur at home, on farm, industrial place, or public place? Industrial While at work? Yes
(d) Means of injury Struck by steel plate

23. Signature Lt Smith Lt Graham M.D. Medical Examiner.

Date signed May 8 1944

G 16970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G 16970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Md.
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Warner Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Shirley Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1944

8. AGE: Years	Months	Days	If less than one day
	3	17	hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation None Child

11. Industry or business

FATHER
12. Name James
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie May Smith
15. Birthplace Baltimore Maryland

16 (a) Informant Blanche Linebarger
(b) Address 702 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 469 N. Mount St. Huntington Ave. Baltimore, Md.

19 (a) (b) Registrar

MAY 8 1944

20. DATE OF DEATH May 5, 1944, at M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculosis of spine

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallamsbee M.D. Medical Examiner.
Date signed May 6, 1944.

G 16971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16971 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Miles Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY A. SPANGLER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Douglas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1877

8. AGE: Years	Months	Days	If less than one day
66	4	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sebastian Fleckenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Wolpert
15. Birthplace Germany

16 (a) Informant Mrs. Catherine M. Spitzner
(b) Address 3640 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Date received by Registrar MAY 8 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1944, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 19 , to May 5 1944, and that I last saw her alive on May 3 19 44.

Immediate cause of death: Coronary Embolism — Duration: 1½ hrs
Due to: Coronary Sclerosis — Duration: about 1 year
Due to: Hypertension — Duration: 6 years
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Moore M. D.
Address 716 Cathedral St. Date signed 5-6-44

16972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G 16972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 N. Howard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annette Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 5 Months Days If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Alexander Patterson
13. Birthplace Va.

MOTHER 14. Maiden Name Charlotte Bond
15. Birthplace Md.

16 (a) Informant Annie Bond
(b) Address 2211 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8/14 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location G. A. County Md

18 (a) Funeral director Mrs Ernest C. Elliott & Son
(b) Address 1129 N. Carrollton Ave

MAY 8 - 1914 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1914 at 7:25 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Intracranial hemorrahage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 5, 1914 at 7:05 P. M. 12/7
(b) Where did injury occur? On the pr. of 728 N. Howard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian, struck by auto,

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed May 6, 1914.

G 16973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 108

G 16973
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Cty. Towsontown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bunker Hill Schoolhouse Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William Oliver Hanna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Mrs Laura Hanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-19

8. AGE: Years 25 | Months 2 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation milk man

11. Industry or business

FATHER
12. Name James O. Hanna
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Hagen
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 5/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Balto. Md.

18 (a) Funeral director E. J. Fogarty & Son
(b) Address 2346 Lafayette Ave.

19 (a) MAY 8 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1944, at 9 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1944 to 5-4 1944, and that I last saw him alive on 5-4 1944.

Immediate cause of death Cardio-Resp. Failure — Duration

Due to Lobar Pneumonia BILATERAL

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill III M. D.
Address Union Memorial Hosp. Date signed 5-4-44

G 16974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16974 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Md
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Nortonia Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Effie Irene Giggard Mrs. Harry E. Giggard

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Harry E. Giggard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1875

8. AGE: Years 69 | Months | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ✓

FATHER 12. Name Zaphaniah Leister
13. Birthplace Maryland

MOTHER 14. Maiden Name Emeline Galbraith
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Gertrude Giggard
(b) Address 3701 Nortonia Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date May 9th 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk
Location Gunpowder Mill Road

18 (a) Funeral director Hester Brooks Bradley Inc
(b) Address 1822 St Paul Place

19 (a) MAY 8 - 1944 (Date received by registrar) Huntington Williams, MD 32 W. University Pkwy

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1944, at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1944, to 5-6 1944 and that I last saw h.c.c. alive on 5-6 1944

Immediate cause of death	Duration
Myocardial failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Naugatuck Jr. M. D.
Date signed 5/6/44

G 16975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G 16975 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Ellsworth St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 2019 Ellsworth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia E. Biggins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Charles R. Biggins
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) June 13 1864
8. AGE: Years 79 Months 10 Days 23 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name William Hinkel
13. Birthplace Baltimore Md.
14. Maiden Name Margaret Donnelly
15. Birthplace Baltimore Md

16 (a) Informant Cecelia M. Leftwich
(b) Address 2019 Ellsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-44 (month) (day) (year)
(c) Cemetery or crematory Garrison Forest
Location Baltimore Co. Md.

18 (a) Funeral director John F. Miller Inc
(b) Address 1111 Druid Park Dr.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1944 at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to 9-6 1944 and that I last saw h alive on 9-5 1944

Immediate cause of death Hypertension — Duration 6 yrs
Due to Cerebral Thrombosis
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Shipley M. D.
Address 500 N Wellington Pk Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G 16976 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARM Carl Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No. 236-14-5570

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Ruth Kurtz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-1902

8. AGE: Years	Months	Days	If less than one day
41	0	10	hr. min.

9. Birthplace Pohocontis Co. W. Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business C. C. Lang & Son

FATHER
12. Name Harm Scott
13. Birthplace Pohocontis Co. W. Va

MOTHER
14. Maiden Name Mary L. Gordon
15. Birthplace Same

16 (a) Informant R. L. Scott
(b) Address 7 Beuford St. Elkins W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or Crematory Arnold Hale Cem
Location Route 250 Elkins W. Va

18 (a) Funeral director Earl L. Hess
(b) Address 715 Light St

MAY 8 - 1944 (Date rec'd by registrar) Huntington West Virginia

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7/1944, at 3.00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to accidental death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia

Due to 1st, 2nd & 3rd degree burns lower extremities & trunk

Other Conditions trunk

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 4/28/44 at 2.30 P.M. (CLANG & SON)
(b) Where did injury occur? Lower ext. & Trunk
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Fell in vat While at work? Yes
(d) Means of injury 1st 2nd & 3rd Degree Burns

23. Signature Dr. Hugh B. McNally M.D. Medical Examiner.
Date signed 5/7/44

G 16977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16977 Registered No. 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Townsend,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John M. Townsend,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 19. 1867

8. AGE: Years 77 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER:
12. Name: William H. Belt,
13. Birthplace: Baltimore Co. Md.

MOTHER:
14. Maiden Name: Mary Ann Brown,
15. Birthplace: Baltimore Co. Md.

16 (a) Informant: Geo. A. Townsend.
(b) Address: 5519 Wesley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 10. 1944 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Grove
Location: Baltimore Co. Md.

18 (a) Funeral director: Robert S. Little,
(b) Address: 2700 Edmondson Ave.

(a) MAY 8 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 7 1944, at Four M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1941, to May 7 1944, and that I last saw h[er] alive on April 4 1944

Immediate cause of death: Arteriosclerotic type of heart disease with hypertrophy & congestive failure

Due to: generalized arteriosclerosis with hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration: several years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. Mitchell M. D.

Address: 2901 Edmondson Ave Date signed: May 7 1944

Approved by Howard J. Madden, M.D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 16978 | CERTIFICATE OF DEATH | 1937 | G 16978

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 763 N. Fine St., W Ward) How long in U. S. If of foreign birth? ...yrs.....mos.....ds.

Length of residence in city or town where death occurred ...yrs.....mos.....ds.

If U. S. Veteran specify WAR.....

2. FULL NAME Harriett Smith

(a) Residence: No. 763 N. Fine St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 17 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	1	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Calvert Co Md

FATHER

13. NAME Augustus Brunt

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Ann Brown

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs Ella Cook

(Address) 703 Fine St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Date 5-10 19 44

19. UNDERTAKER Mrs Frances A. Humphrey

(Address) 5715 Reisterstown Rd

20. FILED MAY 8 - 1944 Howard Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 5-7- 1944

22. I HEREBY CERTIFY, That I attended deceased from June 15 1944 to May 6 1944

I last saw h... alive on May 6 1944. Death is said to have occurred on the date stated above, at 1.45 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Cardio Vascular Disease	?

Other contributory causes of importance:

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Henry Klusmann M. D.

(Address) 2017 Druid Park Ave
2687 Nelson Ave

No. ... WILL BE READING, WITH REGARD TO ... information should be carefully supplied. ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 16979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G 16979 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 Ridgewood Rd
(c) Hospital or institution: miss Helen L. Mair
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Love) F. Louisa Love
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-8-84

8. AGE: Years	Months	Days	If less than one day
63	11	29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Reg Nurse
11. Industry or business

FATHER
12. Name Albert T. Love
13. Birthplace Cooksville Md.

MOTHER
14. Maiden Name Eleanor Bond Jackson
15. Birthplace Md.

16 (a) Informant Records
(b) Address Johns Hopkins Hosp.
17 (a) Cremation (b) Date thereof May 8 44 (month) (day) (year)
(Burial, cremation, or removal)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto Md
18 (a) Funeral director Henry W. Jenkins Sons
(b) Address Mc Culloh & Orchard
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
MAY 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 9 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1944 to 5/7 1944, and that I last saw her alive on 5/7 1944.

	Duration
Immediate cause of death Carcinoma of bladder, Uremia.	2 1/2 yrs.
Due to Carcinoma of bladder Ulcerating urethers.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. A. Linde M. D.
Address Johns Hopkins Hospital Date signed May 8, 44

G 16980

G 16980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6002 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 N. Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY C. FARDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31-1863

8. AGE: Years	Months	Days	If less than one day
80	9	6	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Mathew J. Fardy
13. Birthplace Alexandria Va

MOTHER
14. Maiden Name Louisa C Hoffman
15. Birthplace Balto Md

16 (a) Informant Mrs Mary R Huppmann
(b) Address 2819 Lindwood ave Parkville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Henry N. Jenkins & Sons
(b) Address Mc Culloh & Orchard Sts

19 MAY 8 (Day registrar) (b) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to May 6 1944 and that I last saw h alive on May 5 1944.

Immediate cause of death — Duration
Cyanosis Arteriosclerosis — Sudden
Chronic Myocarditis — Sudden
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel W Beck D.
Address 7777 N Charles Date signed May 7 44

G 16981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G 16981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 S. Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 S. Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anton Lewandowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Catherine - W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Business Man.
11. Industry or business Self

FATHER
12. Name Joseph Lewandowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna
15. Birthplace Poland

16 (a) Informant Joseph Lewandowski
(b) Address 1204 S Clinton St

17 (a) B- (Burial, cremation, or removal) (b) Date thereof 5-10-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Dundalk Ave

18 (a) Funeral director John Kusiq
(b) Address 2329 Eastern Ave

19 MAY 8 - 1944 (Date received by Registrar) (b) Registrar Hamilton Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1944, at 7:50 A. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed May 6, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16982
JO #67606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16982 Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 S. Ann St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Daniels or Antoni Danielak

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1900

8. AGE: Years	Months	Days	If less than one day
44	-1-	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Phillip Daniels (d)
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia ? (d)
15. Birthplace Poland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Dorman Hill Rd.
18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave
19 (a) (b)

MAY 8 1944 Registrar
VS 15F

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1944 19 at 8:45P M

21. I certify that death occurred on the date above stated: that I attended deceased from 5/5 1944 to 5/5 1944 and that I last saw h[illegible] alive on 5/5 1944

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hall M. D.
Address B. C. H. Date signed 5/8/44

Huntington Williams, M.D.

G 16983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 655 W Conway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimo (If outside city or town limits, write RURAL and give town)
(d) Street No. 655 W Conway (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Selina Watkins (Offen)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife R H Watkins
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 25 1887

8. AGE: Years 56 | Months 11 | Days 25/10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Samuel Offa
13. Birthplace Md

MOTHER 14. Maiden Name Mary Stanley
15. Birthplace Md

16 (a) Informant R H Watkins
(b) Address 655 W Conway

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof 5 9 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemty
Location Balto Md.

18 (a) Funeral director Walter B. Long Jr.
(b) Address 1309 N Fremont St.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MAY 8 - 1944 Huntington Avenue, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to May 5 1944 and that I last saw h[illegible] alive on [illegible]

Immediate cause of death	Duration
(a) Cerebro-Vascular	6 Mos
Due to (b) Disease	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R H Watkins M. D.
Address 154 Arlington Date signed 5/8/44

G 16984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G 16984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Bayard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day ht. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 8 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 8 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 11:55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to Cerebral Hemorrhage.

Other Conditions arteriosclerotic Coma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 3/1

(a) Date of injury 4-14-44 at 2:10 A. M.

(b) Where did injury occur? found in Forsby, 1437 E. Baltimore St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Had a stroke + fell to pavement.

23. Signature H. L. Wollenweber M.D. Medical Examiner.

Date signed April 15 1944.

F 0936

G 16985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16985 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Petersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 James Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Botts

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

1944 MAY 8 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28-1944, at 11:45 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis

Due to

Other Conditions Syphilitic aneurysm

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 4-28-44

0935

G 16986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1318

G 16986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive M. Hinton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 30 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Hinton

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 8 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

F 0937

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 9:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Faxton M.D. Medical Examiner.
Date signed April 11, 1944

G 16987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 16987 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139 N. Patterson Park Ave
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME James A. Hall

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife: Maranda F. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1884

8. AGE: Years	Months	Days	If less than one day
59	11	11	hr. min.

9. Birthplace: Sanford Va. (town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Journeyman

FATHER
12. Name: Sefus Hall
13. Birthplace: Va.

MOTHER
14. Maiden Name: Mary Northam
15. Birthplace: Va.

16 (a) Informant: Preston A. Hall
(b) Address: 604 N. Castle St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory: Myrtlewood
Location: Sanford Va.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 MAY 8 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1944, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4-44 to 5-7-44, and that I last saw h[illegible] alive on 5-6-44

Immediate cause of death: Coronary Thrombosis — Duration: 4 Days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: W. H. Thursby M.D.
Address: 1 N. Patterson Park Date signed 5-8-44

G 16988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. G 16988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (Turners Sta.)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 West Pittsburg Ave. (If rural give location) Turners Sta.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1944

8. AGE: Years | Months | Days ½ | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Augustus Watkins
13. Birthplace Laurel Md.

MOTHER
14. Maiden Name Marie Stevenson
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 8 1944 (Date rec'd by registrar) (b) Hunting Williams M.D. Registrar

VS 150

0938

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7 1944, at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1944 to 5-7 1944, and that I last saw her alive on 5-6 1944

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Royer M. D.
Address 500 Carrollton Ave. Date signed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16989 94a Reg. 16989

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. If unknown, so state. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar White

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1880

8. AGE: Years	Months	Days	If less than one day
64	-	20	hr. min.

9. Birthplace Eastern Shore, Maryland (Town, county, and state)
10. Usual Occupation Utility Man
11. Industry or business Gas & Electric

FATHER
12. Name John White
13. Birthplace Eastern Shore, Maryland

MOTHER
14. Maiden Name Charlotte Todd
15. Birthplace Eastern Shore, Maryland

16 (a) Informant Mrs. W. D. Sparks
(b) Address 2736 Riggs Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/8/44 (month) (day) (year)
(c) Cemetery or crematory Dames Quarters
Location Somerset, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1345 St. Paul Street

19 (a) MAY 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944, at 2 45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy / Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 8 1944

G 16990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16990 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Purviance

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marian G. Purviance
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1885

8. AGE: Years 58 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Coal & Wood Dealer

11. Industry or business

FATHER
12. Name Joseph Purviance
13. Birthplace Md

MOTHER
14. Maiden Name Louise Roberts
15. Birthplace Md

16 (a) Informant Marian Purviance
(b) Address 912 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Ashbury Cemetery
Location

18 (a) Funeral director Gray Wilson
(b) Address 1008 Bradley Ave

19 MAY 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to May 7 1944 and that I last saw h alive on May 5 1944

Immediate cause of death: Cardio-Renal-Hypertension — Duration

Due to

Due to

Other Conditions Arteriosclerosis
Hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 1107 Cathedral St Date signed 5/8/44

G 16991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 16991

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Balto City

(b) Street address 1015 S Sharp St

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days) 10 1/2 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1015 S. Sharp St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME Baby George Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Baby

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 26 1943

8. AGE: Years	Months	Days	If less than one day
—	10½	10	hr. — min.

9. Birthplace 1015 S. Sharp St (Balto)
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name Rev Francis T Thomas

13. Birthplace Md

MOTHER

14. Maiden Name Viola Foy

15. Birthplace N. C.

16 (a) Informant Rev Francis T Thomas

(b) Address 1015 S. Sharp St

17 (a) Burial (b) Date thereof May 9/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location A. A. County Cemetery

18 (a) Funeral director Mrs. R. A. Elliott Dgt.

(b) Address 1129 N. Caroline St.

19 (a) — (b) — Registrar

MAY 8 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 — 6 — 1944, at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 — 2 — 1944, to 6 — 6 — 1944, and that I last saw h[illegible] alive on 6 — 5 — 1944.

Immediate cause of death Pneumonia (Bronchial) — Duration

Due to —

Due to —

Other Conditions Chest Congestion

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature James A Aspen M. D.

Address 1016 S Sharp Date signed May 8 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1204

G 16992

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 months

(e) Length of stay in Baltimore (yrs., mos., or days) [redacted]

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4430 Marble Hall Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Helen Kelly Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert W. Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16, 1904

8. AGE: Years 39 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace York Co, Pa, (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Rolf G Neeley

13. Birthplace York Co, Pa,

MOTHER: 14. Maiden Name Nellie Bunting

15. Birthplace Oxford Pa

16 (a) Informant Robert Neeley

(b) Address Delta Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11 1944 (month) (day) (year)

(c) Cemetery or crematory Shanefield

Location Delta, R.D.

18 (a) Funeral director Hubert P Hankins

(b) Address Delta, Pa,

MAY 9 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944 to May 8 1944; and that I last saw h[illegible] alive on May 8 1944

Immediate cause of death Generalized Debilitation — Duration

Due to Colitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 20 44

Major findings of operation: Colitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H H Ingram

Address Md. Penitentiary Date signed 5/9/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16993
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3318 Gardenia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Gardenia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry P Roth Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Maurice Roth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1870

8. AGE: Years 74 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Maurice Pfister
15. Birthplace Balto

16 (a) Informant Margaret Fisher
(b) Address 3318 Gardenia

17 (a) [illegible] Burial (Burial, cremation, or removal) (b) Date thereof May 9-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md

18 (a) Funeral director Philip Heurg Sons
(b) Address 2824 Orleans St

MAY 9 - 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1944 at 6:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 38 to May 1944 and that I last saw h... alive on ... 19...

Immediate cause of death Coronary Thrombosis — Duration 5

Due to Ch. Myocarditis — 11/38 1942

Due to Arterio Sclerosis — 1938

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L Bauer
Address 801 Cumberland Date signed May 7 1944

G 16994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16994
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Eastport Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Bimmes & Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William H. Wootten

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife Saddie Wootten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1873

8. AGE: Years 70 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual Occupation Chauffeur.

11. Industry or business

FATHER
12. Name George Wootten
13. Birthplace Annapolis Md Deceased.

MOTHER
14. Maiden Name Alice Carrell
15. Birthplace Annapolis Md

16 (a) Informant Clarence Wootten
(b) Address Rt. 3 Box 1211 East Port

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11 44 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md

18 (a) Funeral director B. E. Hopkins
(b) Address Annapolis Md.

19 (a) (Signature of registrar) Huntington Williams, M.D. (b) MAY 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8/44 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1944 to 5/8 1944, and that I last saw h/ alive on 5/8 1944

Immediate cause of death: Diabetes Coma. Uremia.

	Duration
	7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Queen M.D.
Address Mary Hog Date signed 5/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16995 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1048 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva R. McCall

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or divorced Widowed

6 (b) Name of husband John C. McCall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th 1858

8. AGE: Years 85 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William Neal
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J. Stevens
15. Birthplace Md.

16 (a) Informant Maud E. Arendt
(b) Address 613 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 MAY 9 - 1944 (Date rec'd by registrar) Penalty for false statement: $100 to $500 fine and imprisonment. Williams M.R. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th 1944, 12:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29 1944 to 5/7 1944, and that I last saw h[illegible] alive on 5/7 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S.C. Smith

Address 1223 E. North Ave Date signed 5/8/44

G 16996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 939

Registered No. G 16996

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) ~~Hospital or~~ institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 Woodholme Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida R. Hamel

3 (b) If veteran, name war —
3 (c) Social Security Account No. none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jake G. Hamel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 19th 1872
8. AGE: Years 71 | Months 5 | Days 18 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Louis Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant George L. Hamel
(b) Address 3124 Woodholme Ave
17 (a) Burial (Burial, cremation or removal) (b) Date thereof 5/9/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st
19 Filed MAY 9 - 1944 Registrar Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1944, at 7 a M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1940, to May 7 1944, and that I last saw her alive on May 5 1944.

Immediate cause of death: Chronic myocarditis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. M. Culbertson M. D.
Address 324 Reisterstown Rd Date signed 5/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 739

G 16997 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Edmondson ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Santo Locicono

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rosaria Locicono

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1889

8. AGE: Years 55 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Shoe maker

11. Industry or business Self

FATHER
12. Name Salvatore Locicono
13. Birthplace Italy

MOTHER
14. Maiden Name Guiseppi Cordinale
15. Birthplace Italy

16 (a) Informant Mrs Rosalia Locicono.
(b) Address 2038 Edmonson ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Harley St.

(a) (b)
(Date filed by Registrar) Registrar

MAY 9 - 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944 at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1944 to May 8 1944 and that I last saw him alive on April 8 1944.

	Duration
Immediate cause of death Respiratory failure	12 hrs.
Due to Aplastic Anemia	3 mos.
Due to	
Other Conditions Terminal Pneumonia.	24 hours

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul R. Zeigler. M. D.

Address Mercy Hosp. Date signed 5-9-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 S. Conkling St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S. Conkling Sta
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Vogel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-19-1874

8. AGE: Years	Months	Days	If less than one day
69	8	17	hr. min.

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation Bricklayer

11. Industry or business

FATHER 12. Name David Vogel

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Christina Koessli

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Sophia Fruehauf

(b) Address 233 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Eastern Ave & Rd.

18 (a) Funeral director John P. Donnelly

(b) Address 418 Eastern Blvd.

19 (a) (b) Huntington Williams, M.D. Address 234 E. Conkling St Date signed 5-8-44
(Filing receiving deputy registrar)

MAY 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6-44 19 , at 6:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11-44 19 , to 5-6-44 19 , and that I last saw h alive on 5-6-44 19 .

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine, M.D. M. D.

G 16999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 16999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution:
Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ years
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Snyder (SNEIDER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m.	W.	married

6 (b) Name of husband or wife Jessie Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62	-	-	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Sholom Snyder
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant Milton Snyder (SON)
(b) Address 2711 Windsor Ave

17 (a) Burial (b) Date thereof 5-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 143 E. Balto St

MAY 9 - 1944
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1940, to 5-8 1944, and that I last saw him alive on 5-8 1944

Immediate cause of death Right cerebral haemorrhage
Arteriosclerosis, Hypertension

Duration 5-6-44

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin

Address Levindale Date signed 5/8/44

G 17000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VA. (b) County
(c) City or town SUFFOLK (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 BREWER AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard J Freidlander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
21			hr. min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name WILLIAM FRIEDLANDER
13. Birthplace BALTO.

MOTHER
14. Maiden Name CECELIA
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-9-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO + CONKLIN ST

18 (a) Funeral director JACK LEWIS Inc.
(b) Address 1437 E. BALTO. ST.

19 (a) MAY 9 1944 (Local Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7/1944, at 9:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27/1944, to 5/7/1944, and that I last saw h[illegible] alive on 5/7/1944

Immediate cause of death Pulmonary edema — Duration

Due to

Due to

Other Conditions Leukemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp Date signed 5/7

G 17001 10 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

V G 17001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 KEYWORTH AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BOLTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 KEYWORTH QUE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES GUREVITCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name WOLF
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant MR. HEYERHOFF
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-9-44 (month) (day) (year)
(c) Cemetery or crematory WINDSOR HILL RD
Location WINDSOR HILL RD

18 (a) Funeral director Jack Levine Sons
(b) Address 1437 E. Baltimore St

MAY 9 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-44 19 , at 11 9. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1935 to May 8 1944. and that I last saw him alive on May 7 1944

Immediate cause of death Myocardial failure with pulmonary oedema

Due to Myocarditis

Due to

Other Conditions High blood pressure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
10 hours
9 years
9 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Pushman M. D.
Address 2338 Eutaw Pl. Date signed May 8-44

17002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G 17002 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2436 LINDEN AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. CLOVERDALE APTS
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ARTHUR GRUNWALD

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-18-7389

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MANJA.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace HUNGARY (Town, county, and state)
10. Usual Occupation MATTRES BUSINESS
11. Industry or business COMFY MFG. Co.

FATHER
12. Name SIGMUND
13. Birthplace HUNGARY

MOTHER
14. Maiden Name ROSALIE
15. Birthplace HUNGARY

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-10-44 (month) (day) (year)
(c) Cemetery or crematory BETH EL [illegible] Ship
Location [illegible] PHILA ROAD
18 (a) Funeral director JACK LEWIS INC.
(b) Address 1439 E. BALTO ST
MAY 9 - 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944, at 12:12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942, to 5-8 1944, and that I last saw h.i.m. alive on 5-7 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to: Coronary sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Hans Blx M. D.
Address 2516 Linden Ave. Date signed 5-8-44

17003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17003 Registered No. 940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2732 Baker St-
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Garrison Hack

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 217-03-1091

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lottie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation Westminster Shoe Co
11. Industry or business Mfg. Shoes

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V-9-44 (month) (day) (year)
(c) Cemetery or crematory Windsor Hill Rd
Location Windsor Hill Rd

18 (a) Funeral director Yock Lewis, Inc
(b) Address 1459 E. Balto St.

19 Date rec'd by Local Reg. MAY 9 - 1944 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH V-7-44 19 , at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7th 4th 1943, to May 7 1944, and that I last saw h[illegible] alive on May 7th 1944

	Duration
Immediate cause of death: Coronary Thrombosis	10 days
Due to: Coronary disease + Angina pectoris	5-6 yrs
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Seymour Pesh M. D.
Address 220 N. North Date signed

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17004 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Riverside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Vogelsang

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances B. Hohen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/19/1872

8. AGE: Years 71 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Vogelsang
13. Birthplace Baltimore

MOTHER
14. Maiden Name M. Cook
15. Birthplace Baltimore

16 (a) Informant Mrs. J. B. Vogelsang
(b) Address 1210 Riverside

17 (a) Burial (b) Date thereof 5/10/44
Burial, cremation, or removal (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Loudon Park

18 (a) Funeral director J. J. Fahey Sons
(b) Address 318 Light St.

19 (a) [illegible] Washington Williamsport Md.

MAY 9 1944

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8/44 19 , at 12 M

21. I certify that death occurred on the date above stated that I attended deceased from 5/3/44 19 to 5/8 19 44
and that I last saw h. alive on 5/7 19 44

Immediate cause of death Coronary Thrombosis — Duration 3 days

Due to

Due to Arterio Sclerosis

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Nutter M.D.

Address 1210 Riverside Ave Date signed 5/10/44

G 17005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 Walbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Topper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie Thomberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1878

8. AGE: Years 65 | Months 4 | Days 17 | If less than one day hr. min.

70

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER
12. Name John J. Topper
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Voorthees
15. Birthplace Md.

16 (a) Informant Mrs. Annie Topper
(b) Address 2133 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Zeltzer & Son
(b) Address 1827 W. North Ave.

19 MAY 9 - 1944 (Date rec'd by Reg.) Huntington Williams, M.D. (Signature of Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 11.05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 8 1944

(OVER)

17006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 17006
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3610 Parkdale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Parkdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia P. Brown.

3 (b) If veteran, name —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1944

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Albert F. Brown.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ellen V. Preston.
15. Birthplace Maryland.

16 (a) Informant Albert F. Brown.
(b) Address 3610 Parkdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Ebenezer H. Donovan
(b) Address 3615-17 Eastern Ave.

19 MAY 9 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to May 8 1944 and that I last saw h[illegible] alive on May 8 1944

Immediate cause of death: Premature birth 22 wks — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 2020 N. Clark Date signed 5-9/44

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

17007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G 17007 Registered No.

PLEASE WRITE CONFORMABLY. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Catons Aves.
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 S. Mount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Gettier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter Tate | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1878

8. AGE: Years 66 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Watts
13. Birthplace Md

MOTHER
14. Maiden Name Alcesta Martin
15. Birthplace Md

16 (a) Informant Mrs Basil Watts
(b) Address 316 S Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 9 44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Elkridge

18 (a) Funeral director Harry Weinberg
(b) Address 1600 Edmondson Ave Balto

19 MAY 9 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1944 to 5/7 1944, and that I last saw her alive on 5/7 1944.

	Duration
Immediate cause of death: Bronchopneumonia	1 week
Due to: Coronary Thrombosis	1 month
Due to:	
Other Conditions: Embolus, left leg; Uterine tumor	1 week

(Include pregnancy within 3 months of death)

Date of operation prev

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature J R Duncan MD M. D.
Address 5T. Agnes Hosp Date signed 5/7/44

17008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17008 Registered No.

YA-86815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mery Strohmer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1869

8. AGE: Years	Months	Days	If less than one day
74	10	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew Strohmer (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Rosalie Eff
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4500 Harford Rd.

18 (a) Funeral director Harry H. Wirtz
(b) Address 4101 E. Lanvale Ave.

MAY 9 - 1944 Harry H. Wirtz Milwaukee

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1944, at 8:35 A

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1944, to 5/8 1944, and that I last saw her alive on 5/8 1944

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions ASCVD

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. E. L. Lerman M.D.

Address Date signed 5-9

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G 17009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

G 17009
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Wilcox Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15 42

8. AGE: Years 2 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore -
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leroy Lee -
13. Birthplace Balto -

MOTHER 14. Maiden Name Helen
15. Birthplace

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Ellwood
(b) Address 1129 N. Carrollton St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 9 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1944 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944 to May 7 1944 and that I last saw him alive on May 7 1944

Immediate cause of death Meningococcemia
Due to Adrenal Failure

Duration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: G.A. NL

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson Smith
Address Johns Hopkins Hosp. Date signed 5/7/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167

G 17010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, ~~Maryland~~
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Simms

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-3492

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1911

8. AGE: Years	Months	Days	If less than one day
32	9	9	hr. min.

9. Birthplace Chester, S. C. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Monroe Simms
13. Birthplace S.C.

MOTHER
14. Maiden Name Alexander
15. Birthplace S.C.

16 (a) Informant Mary Dixon
(b) Address 921 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) MAY 9 1944 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1944, at 10:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-5-44 at 10 P. M.
(b) Where did injury occur? In front of 913 Jordan Alley
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Knifed during altercation

23. Signature H. L. Wollenmeber M.D.
Medical Examiner.
Date signed May 6, 1944.

VS 151

G 17011 ✓ G 17011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Howard Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 78
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Howard Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH CHAUNCEY REESE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Phoebe Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1865

8. AGE: Years	Months	Days	If less than one day
78	4	24	hr. min.

9. Birthplace: Ellicott City, Md.
(Town, county, and state)
10. Usual Occupation: Retired Salesman
11. Industry or business: Jewelry

FATHER
12. Name: W. John Reese
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mrs. Lois Faulkner
(b) Address: 3002 Howard Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/9/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 9 1944 Wilmer Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1944, at 3:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1944 to 5/7 1944, and that I last saw h[illegible] alive on 5/6 1944.

Immediate cause of death: Angina Pectoris

Due to	Duration
Hardening of arteries	5 yrs - 5 yrs
Other Conditions old age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (—)
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. C. Hearn M. D.
Address 1907 Garrison Blvd Date signed 5/9/44

G 17012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

V G 17012 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Orkney Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Orkney Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY EMMA SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Emory W. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1872

8. AGE: Years	Months	Days	If less than one day
72	3	16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Rev. Benjamin Franklin Clarkson
13. Birthplace Pa.

MOTHER
14. Maiden Name Laura Jane Kelly
15. Birthplace Md.

16 (a) Informant Miss Elizabeth Pearson
(b) Address 502 Orkney Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. (by telephone for Williams, M.D.)

MAY 9 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 6, 1944, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 1944 to May 6 1944, and that I last saw her alive on May 6 1944.

Immediate cause of death	Duration
Congestive Heart Failure	1 day
Due to Endocarditis. Myocarditis	10 yrs.
Due to	
Other Condition Chr. Cholecystitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Earl H. Benson, M.D.
Address 5111 York Rd Date May 8, 1944 M. D.

Correct age is especially important. Physicians: please write plainly. Do not abbreviate.

G 17013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D G 17013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmount & Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Chelsea Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie E. Ringgold

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Charles W. Ringgold

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1870

8. AGE: Years 74 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Charee, Maryland
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Calvin Disharoon
13. Birthplace Md.
14. Maiden Name Hester Price
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Deals Island Cem.
Location Deal's Island Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

MAY 9 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944, to May 7 1944, and that I last saw her alive on May 7 1944

Immediate cause of death: Pulmonary Embolus — Duration 2 min.

Due to Arteriosclerotic Heart Disease — Duration ?

Due to — Duration

Other Conditions Auricular Fibrillation — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Greeley M. D.
Address Church Home & Hospital Date signed 5/9/44

Write the names of cities, counties and states. Correct age is especially important. Physicians: please write

G 17014

JL - 87445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 17014

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2401 Kloman St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KAIRIS
Vincent Kairis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-8784

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known ?

8. AGE: Years	Months	Days	If less than one day
43 ?			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER

12. Name Thomas Kairis

13. Birthplace Lithuania

MOTHER

14. Maiden Name Anna Urbanvich

15. Birthplace Lithuania

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof May 11-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4430 Belair Road

18 (a) Funeral director John J. Grebliunckas Jr.

(b) Address 423 S. Paca St

19 MAY 9 - 1944 (b) Registrar

Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1944 at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1944, to 5-8 1944, and that I last saw him alive on 5-8 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No chart

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul Hatton

Address B. C. H. Date signed M/D 5/8/44

Correct age is especially important. Physicians: please write plainly.

G 17015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verma Shepard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Edward Shepard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18 1901

8. AGE: Years 42 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Chestertown, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name George Brown

13. Birthplace Chestertown, Md

MOTHER 14. Maiden Name Mary Catherine Brown

15. Birthplace Chestertown, Md.

16 (a) Informant Mrs. Hyumman Brown

(b) Address 755 Dover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Winans, Md

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Belnord Ave.

19 (a) (b) Huntington Williams, M.D. Registrar

(Date rec'd by Local Reg.) MAY 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7/1944, at 1:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 5/7/44

G 17016

G 17016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1461 N. Carey St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1461 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Howard Day

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1891

8. AGE: Years 53 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Northumberland County, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Yeatley
13. Birthplace Va

MOTHER
14. Maiden Name Fannie Taylor
15. Birthplace Va

16 (a) Informant Martha Jackson
(b) Address 1461 N. Carey

17 (a) Buried (b) Date thereof 5-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Northumberland Co-Va

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Mt. Street

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1944, to May 7 1944, and that I last saw h[illegible] alive on May 7 1944.

Immediate cause of death — Duration

Thyrotoxicosis

Due to Hyperthyroidism 3 mo.

Due to

Other Conditions Diabetes Mellitus
Hypertension
(Include pregnancy within 3 months of death)

Date of operation 5/6/44

Major findings of operation: Goiter

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Higgins M.D.

Address 243 Madison Ave Date signed 5/8/44

CORRECT AGE IS ESPECIALLY IMPORTANT. If physician prefers, please write date of birth instead of age.

17017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 17017 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N.Pat.Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N.Pat.Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E.Gerber

3 (b) If veteran, name war -----
3 (c) Social Security Account No. -----

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife F.H.Louis Gerber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.19,1865

8. AGE: Years	Months	Days	If less than one day
78	7	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Laura ---
15. Birthplace Germany

16 (a) Informant Mrs.Huber
(b) Address 907 N.Pat.Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto.Md.

18 (a) Funeral director Phillips Mowry Sons
(b) Address 2024 Orleans St.
(c) MAY 9 - 1944 (Date rec'd by registrar) Hampton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6/44 19 , at 1:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29, 1941, to May 6, 1944, and that I last saw h.w alive on May 5 1944.

Immediate cause of death: Chronic Myocarditis — Duration 3 yrs
Due to Arteriosclerotic Cardiovascular Renal Disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. L. Wolfe M.D.
Address 1331 E. North Ave. Date signed 5-8-44

correct age is especially important. Physicians: please write the

17018

452620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G 17018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celeste Keith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-93

8. AGE: Years 50 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name John L. Keith
13. Birthplace DC

MOTHER 14. Maiden Name Jerolean Plymon
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mr. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Registrar) (b) Huntington Williams, M.D. (Registrar)

MAY 9 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1944 at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944 to May 6 1944 and that I last saw alive on May 6 1944

Immediate cause of death: Carcinoma, ovary c Metastases, Abdominal — Duration: 3 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Apr. 2 18, '44
Major findings of operation: Carcinomatosis peritonei
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger B. Scott M.D.
Address Johns Hopkins Hosp. Date signed May 6-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 17019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17019 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 Wilson
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) [illegible] Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Wilson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry Campbell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months 43 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm Thompson

13. Birthplace Harford Co. Md.

MOTHER 14. Maiden Name Eliza Shepard

15. Birthplace Upper Thode, Md.

16 (a) Informant Henry Campbell

(b) Address 535 Pitkin St. (Wilson St.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Hyatt

(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

MAY 9 - 1944

File No. Hunter Williams M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5 1944, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1944, to 5-5 1944, and that I last saw h alive on 5-5 1944.

Immediate cause of death Pneumonia — Duration: 3 mo

Due to Fractured Femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-3-44 at 14/2 M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury Fell down stairs

23. Signature H. C. Williams M. D.

Address 1131 Hoban Date signed 5-3-44

WZW also number and Arthur Gamon

G 17020

YA-70475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17020 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2, 4, 27days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Hart.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
62?			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Street Cleaner
11. Industry or business

FATHER 12. Name Daniel Hart
13. Birthplace England

MOTHER 14. Maiden Name Mary Purcell
15. Birthplace New York City

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 5 10 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St Paul St.
19 (a) (b)
(Signature of registrar) Registrar

MAY 9 1944

VS 150

Hamilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1944 at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1943 to 5-8 1944 and that I last saw h[illegible] alive on 5-4 1944.

Immediate cause of death Intracerebral Hemorrhage — Duration 2 days

Due to Hypertensive Cardiovascular Disease — Duration ?

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: The above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Hahne M. D.

Address B.C.H. Date signed 5/8/44

Correct age is especially important. Physicians: please [illegible]

G 17021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17021 Registered No. 1382

YA-88729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) Balto Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1255 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Venable

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Bettie Venable
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-2-1885 or 3-27-1890?

8. AGE: Years	Months	Days	If less than one day
54? 58?	2	4? 8?	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henderson Venable (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie ? (d.)
15. Birthplace Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (b) Date thereof 5-9th 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md.
18 (a) Funeral director Bryson Mamie & Knight
(b) Address 721 Pulaski St
19 MAY 9 - 1944 (c) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1944, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1944, to 5/6 1944, and that I last saw h[illegible] alive on 5/6 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Hall M.D.
Address B.C.H. Date signed 5/7/44

Do not use if especially important. Physician, please

G 17022

G 17022

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town) Co
(d) Street No. 111 Oak St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Hassan.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 3-17-1863

8. AGE: Years	Months	Days	If less than one day
81	1	19	hr. ... min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business Sexton of Church

FATHER
12. Name Max Hassan
13. Birthplace Egypt

MOTHER
14. Maiden Name Emma ?
15. Birthplace Hamburg-Germany

16 (a) Informant Edna F Bowyer
(b) Address 111 Oak St Turners Sta

17 (a) Burial (b) Date thereof 5 9 44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

(a) Date received MAY 9 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/1944, at 7 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31/1943 to 5/6/1944 and that I last saw h.. alive on 5/6/1944.

Immediate cause of death Hypertension
Cardio Vascular Disease

Due to Arteriosclerosis

Due to

Other Conditions Post operative for Hypertrophied Prostate (Include pregnancy within 3 months of death)

Date of operation 9/11/43

Major findings of operation: Enlarged Prostate Gland

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. M. E. Wilson
Address Provident Hosp Date signed 5/9/44

correct age is especially important. Physicians: please write

G 17023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1570

G 17023 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3235 Clifmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3235 Clifmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virgie Wilt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1943

8. AGE: Years	Months	Days	If less than one day
	4	13	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Wilt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dolores Wanner
15. Birthplace Baltimore Md

16 (a) Informant Mr John Wilt
(b) Address 3235 Clifmont Ave

17 (a) Burial (b) Date thereof 5-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location

18 (a) Funeral director Leonard Kane
(b) Address 5305 Harford Rd

19 (a) Filed 1944 (b) Registrar
(Date filed by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to May 7 1944 and that I last saw h[illegible] alive on May 7 1944

Immediate cause of death: Respiratory failure — Duration 8 hrs

Due to Hydrocephalus and Spinal bifida

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature G. Burns Hollandsworth M. D.
Address 2937 N. Charles St Date signed 5/8/44

Huddleston Williams, M.D. Registrar

G 17024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 17024 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 S.ROBINSON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S.ROBINSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M.JONES

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212 18 2599

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: CHARLES H.JONES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV.27 1862

8. AGE: Years	Months	Days	If less than one day
81	5	9	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business FOOTS CAN CO.

FATHER
12. Name FRANK J.SCHAECH
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY E.SCHNEIDER
15. Birthplace GERMANY

16 (a) Informant MARY E.BAUERNFEIND(DAUGHTER)
(b) Address 415 S.ROBINSON ST.

17 (a) BURIAL (b) Date thereof MAY 9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

9 (a) 1944 Huntington Williams, M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 6 1944 at 3/45 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to May 6 1944 and that I last saw h alive on May 5 1944

Immediate cause of death
Carcinoma of Sigmoid
Hypertension Cardio-Vascular Renal

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Hunsrucker M.D.
Address 250 S Eaton St. Date signed 5/10/44

G 17025 G 17025

453413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Bauernfeind

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-72

8. AGE: Years	Months	Days	If less than one day
71	7	8	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation PRINTER

11. Industry or business

FATHER
12. Name John Bauernfeind
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Hoffman
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 11/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeller (XC.
(b) Address 403 S. WOLFE ST.

MAY 9 1944 (Date received) Huntington Williams, M.D. (Registrar) Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH May 8 1944 at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1944 to May 8 1944 and that I last saw him alive on May 8 1944.

Immediate cause of death	Duration
Acute hypostatic pneumonia	6 days
Due to Carcinoma of bladder	1 yr. a mo.
Due to	
Other Conditions AR hypertension generalized	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ✓

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ronald R. Ross, M.D.
Address Johns Hopkins Hosp. Date signed 5/9/44

correct age is especially important. Registrars please

VS 180

4538 G 17026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58D

G 17026
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto 21
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Poplar Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Regulska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-38

8. AGE: Years 6 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Regulska
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ratajczak
15. Birthplace Buffalo NY

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Ann st

19 (a) (Date rec'd by registrar) Huntington Mills Registrar
MAY 9 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to May 7 1944, and that I last saw her alive on May 7 1944.

Immediate cause of death: Heart Failure. — Duration

Due to: Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson Guild
Address Johns Hopkins Hosp Date signed 5/12/44

correct age is especially important. Physicians, please answer

G 17027 HEALTH DEPARTMENT—CITY OF BALTIMORE 17027

CERTIFICATE OF DEATH

1937

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 W University Pk St., 7-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 76 yrs. 1 mos. 9 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Rosa Egerton Whiting Parran

If U. S. Veteran specify WAR.....

(a) Residence: No. 914 W. University Pkwy St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

6a. If married, widowed, or divorced (or) WIFE of Samuel Parran

6. DATE OF BIRTH (month, day, year) March 30, 1868

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	1	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) 1943

11. Total time (years) spent in this occupation life

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME William Perrin Whiting

14. BIRTHPLACE (city or town) (State or country) Hampton Va

MOTHER

15. MAIDEN NAME Rosetta Egerton

16. BIRTHPLACE (city or town) (State or country) St Mary's Co. Md.

17. INFORMANT Samuel Parran (husband)
(Address) 914 W University Pkwy

18. BURIAL, CREMATION, OR REMOVAL
Place Greenmount Date May 9 1944

19. UNDERTAKER Steward Mount Co.
(Address) 1015 W Fayette St

MAY 9 1944

20. FILED ..... 19 ..... Registrar.

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 7, 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept, 1943, to May 7, 19...

I last saw her alive on May 6, 1944. Death is said to have occurred on the date stated above, at 2:15 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	1942

Other contributory causes of importance:

Arteriosclerosis	[illegible]

Was an operation performed? no Date of .....

For what disease or injury? —

Name of operation — Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury ..... 19...

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify .....

(Signed) Francis W. Slusk, M. D.

(Address) 715 Park Ave

17028 452600 D

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

G 17028 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 E. Monument Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lue Hom. (Sue-May-Hom)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Yellow	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-24

8. AGE: Years	Months	Days	If less than one day
19	4	19	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Chung Hom
13. Birthplace Calif.

MOTHER
14. Maiden Name Mary Lee
15. Birthplace China

16 (a) Informant Brenda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn
18 (a) Funeral director Edward Memorial,
(b) Address 108 W. Mosher Ave.
19 (a) (b) Date received by Registrar

MAY 9 - 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944 at 6 1/2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 44 to May 7 1944 and that I last saw h[illegible] alive on May 7 1944

Immediate cause of death	Duration
Heart failure	
Due to Rheumatic heart disease (chronic) & auricular fibrillation	
Due to mitral sten + insuff ? adhesive mediastino	
Other Conditions pericarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John R. Birmingham M.D.
Address JHH Date signed 5/7

G 17029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17029 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Thompson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Wm G Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1889

8. AGE: Years 54 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business —

FATHER
12. Name Wm Cumnock
13. Birthplace Scotland

MOTHER
14. Maiden Name Cunningham
15. Birthplace Scotland

16 (a) Informant Wm A Thompson
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12 1944 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director T.C. Higinbothom
(b) Address Ellicott City Md

19 (a) MAY 9 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1944, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1944 to 5-8 1944 and that I last saw h.er alive on 5-8 1944.

Immediate cause of death Suffocation — Duration

Due to Stopped breathing

Due to Hypostatic pneumonia - Renal disease

Other Conditions Colostomy since 1936

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Reinhart M. D.
Address University Hospital Date signed 5-9-44

Correct age is especially important. If uncertain, please write this

GS 150

G 17030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17030 / 469 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Linden Avenue (If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Odendhal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1868

8. AGE: Years 75 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name James Mc Ginn
13. Birthplace Ireland

MOTHER — 14. Maiden Name Catherine Mc Kenna
15. Birthplace Ireland

16 (a) Informant Sebastian Odendhal
(b) Address

17 (a) Burial (b) Date thereof 5/11/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 9 1944 — Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1944, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1944, to 5-8 1944, and that I last saw h[illegible] alive on 5-8 1944.

Immediate cause of death: Possible carcinoma of pancreas — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Krzyzowski M. D.
Address Mercy Hosp. Date signed 5-8-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17031 G 17031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Blythewood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Maguire

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26-1878

8. AGE: Years 60 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Private family

MOTHER / FATHER
12. Name Jeffinia Maguire
13. Birthplace Ireland
14. Maiden Name Mary Nicholson
15. Birthplace Ireland

16 (a) Informant Mr. Timothy Maguire
(b) Address 2573 W. Fayette St

17 (a) Burial (b) Date thereof 5/11/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory New Cathedral
Location 4700 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 2003 Harford Ave

19 MY 9-1944 (a) Hamilton Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-44 19 at 10 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1944 to 5-8 1944 and that I last saw h[illegible] alive on 5-8 19 44

Immediate cause of death Carcinoma of cervix & metastases — Duration 15 da

Due to

Due to

Other Conditions Arteriosclerotic cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation Dec. 43

Major findings of operation: Carcinoma.

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Clyamore M. D.

Address St. Joseph's Hosp. Date signed 5-8-44

Physicians: please write the causes of death clearly and legibly. Age is especially important.

G 17032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17032 / 132

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 S. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L Doyle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 15, 1899

8. AGE: Years	Months	Days	If less than one day
44	11	22	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Sheet metal worker

11. Industry or business Brandt Co.

FATHER
12. Name Lawrence Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Byrne
15. Birthplace Ireland

16 (a) Informant Mrs John J. Doyle
(b) Address 4730 Fred Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem.
Location 1300 Maryland Ave

18 (a) Funeral director John J Conway & Son
(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 10:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Eustace M.D. Medical Examiner.

Date signed May 9, 1944

MAY 9 1944

G 17033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17033 Registered No. 832a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9-44
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1842 W Fratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline De Carlo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: late John De Carlo | 6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Oct 3rd 1880

8. AGE: Years 62 63 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER 12. Name Jacleman DiSantis

13. Birthplace Italy

MOTHER 14. Maiden Name Alexandra

15. Birthplace Italy

16 (a) Informant Mrs. Lucy Simeone

(b) Address 41 S. Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem Location 4439 Bdwy Road

18 (a) Funeral director John Conner & Son

(b) Address 901 & 903 Gallows St

19 (a) Registrar (b) Huntington Williams M.D.

MAY 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6/44 19 to 5/8/44, and that I last saw h[illegible] alive on 5/8/44 19

Immediate cause of death	Duration
Respiratory failure	
due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington J. Bryson M.D.

Address St Agnes Hosp Date signed 5/10/44

(COVER)

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17034 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LOMBARD & GREENE STS
(c) Hospital or institution:
UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 46 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County –
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. CAROLINE ST. (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country

3 (a) FULL NAME AUSTON CLEVELAND PASQUITH

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MAR.
6 (b) Name of husband or wife: Ruth C. Pasquith
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 9-19-'84

8. AGE: Years 59 | Months 6 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace NORTHUMBERLAND CO., VA (Town, county, and state)
10. Usual Occupation BUSINESS MAN
11. Industry or business PRODUCE STORE

FATHER
12. Name WILLIAM W. PASQUITH
13. Birthplace VA.

MOTHER
14. Maiden Name LUCIE CHITWOOD
15. Birthplace VA.

16 (a) Informant MRS. RUTH C. PASQUITH
(b) Address 1707 N CAROLINE, ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 10 (day) 44 (year)
(c) Cemetery or crematory Lorraine Park Cem
Location 5608 Rothwood Road
18 (a) Funeral director Robert Brophy & Son
(b) Address Baltimore & Hollins St.
19 (a) ... (b) ...
(Date received) Registrar
MAY 9 1944 Huntington Williams, M.D.
VS 1B

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 8 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ..., and that I last saw h... alive on ... 19 ...

Immediate cause of death PULMONARY EDEMA — Duration ...
Due to MYOCARDIAL FAILURE — Duration ...
Due to CORONARY THROMBOSIS — Duration ...
Other Conditions — Duration ...

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature LeRoy W. Tifft
Address Univ. Hosp. Date signed 5-8-44

Correct age is especially important. Physician, please write in full.

G 17035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 164 C

G 17035

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore Maryland

(c) Hospital or institution: South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State California (b) County

(c) City or town Santa Monica (If outside city or town limits, write RURAL and give town)

(d) Street No. 937 C. 20th Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank M. Cook

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 557-16-5605

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1887

8. AGE: Years 57 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace San Francisco Calif. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Christian D. Cook

13. Birthplace Germany

MOTHER — 14. Maiden Name Anna M

15. Birthplace Germany

16 (a) Informant Mrs. Margaret Cook Falterman

(b) Address 2241-24th St. Santa Monica Calif.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof May 9 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park.

Location Frederick Ave

18 (a) Funeral director Wm J Ticknet Son

(b) Address N Pitt Ave

19 (a) (Date received by registrar) (b) Hunt Bryton Williams, M.D.

MAY 9 1944 VS

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suicide - Bullet wound of head.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-2-44 at 11:30 P.M.

(b) Where did injury occur? Maryland Drydock Fairfield

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? Yes

(d) Means of injury Revolver.

23. Signature H L Wollenweber M.D. Medical Examiner.

Date signed May 3, 1944.

17036

BALTIMORE CITY HEALTH DEPARTMENT

JO # 87749

CERTIFICATE OF DEATH 93D

G 17036
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 9 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John N. Dersch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1883

8. AGE: Years 60 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired Bus Agent

11. Industry or business Bus

FATHER
12. Name John
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Brendel
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 Date rec'd by local reg. (b) MAY 9 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1944, at 4:05PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1944 to 5/6 1944 and that I last saw h[illegible] alive on 5/6 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 4 d.
Due to: H.C.V.D.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seymour M. D.
Address UCH Date signed 5/7

Rigaldo

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17037
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2638 E. Baltimore St.
(c) Hospital or institution: St. Elizabeth's Church - St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2638 E. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Rigaldo

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1881

8. AGE: Years	Months	Days	If less than one day
63 - 62	1	19	hr. min.

9. Birthplace Trenton N.J.
(Town, county and state)

10. Usual Occupation Teacher

11. Industry or business

MOTHER / FATHER

12. Name Wm Lehambes

13. Birthplace Trenton N.J.

14. Maiden Name Mary Britton

15. Birthplace Trenton N.J.

16 (a) Informant Sr. Frances Mitchell

(b) Address Lakewood Pharmacy

17 (a) Burial (b) Date thereof May 10-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road.

18 (a) Funeral director John J. Hoey

(b) Address 3000 E. Baltimore St.

MAY 9 - 1944 Hamilton Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 (May) 7 1944 at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to — 19 and that I last saw her alive on 19

Immediate cause of death	Duration
Pathetic History Dead on Arrival - Coronary history - ? Dec. to Coronary occlusion.	
Due to Arteriosclerotic C.V.D.	
Due to Diabetes.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 5/7/44
M.D.

correct age is especially important. Physicians: please write the

C 17038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

✓ C 17038 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 2025 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Ida M. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24-1913

8. AGE: Years	Months	Days	If less than one day
31	3	14	hr. min.

9. Birthplace York, Pa. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER
12. Name Wm. J. Anderson
13. Birthplace York Pa.

MOTHER
14. Maiden Name Mary Wintermyer
15. Birthplace ?

16 (a) Informant Mary Anderson
(b) Address York Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location York Pa

18 (a) Funeral director Wm J Tschudy
(b) Address Md. Penna

19 (a) MAY 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944, at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 8 1944 M.
(b) Where did injury occur? 2035 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Inhaled gas from stove

23. Signature [illegible] M.D. Medical Examiner.
Date signed May 8 1944

G 17039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59a

G 17039 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr 23 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Dorchester
(a) State Maryland (b) County Talbot Co.,
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Mill St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wells Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1871

8. AGE: Years 73 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Melvale, Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Wells Small
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Alsop
15. Birthplace Fredericksburg, Va

16 (a) Informant Home for Incurable Negroes
(b) Address 700 W. 40th St. per M.F.W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1943, to 5/8 1944, and that I last saw him alive on 5/8 1944.

	Duration
Immediate cause of death: Hematuria (Bladder Tumor?)	1 month
Due to	
Due to	
Other Conditions: Rheumatoid Arthritis (Stilbestrol)	50 Yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hesperger, M.D.
Address 214 Medical Arts Bldg. Date signed 5/8/44

VS 8

Please write the causes of death clearly and legibly. Spelling important. Abbreviations: please write the

17040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G 17040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 N. Smallwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 N. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HERMAN GREVEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1904

8. AGE: Years	Months	Days	If less than one day
40	1	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Charles Grevey
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Minnie H. Hermann
15. Birthplace Germany

16 (a) Informant Mrs. Minnie H. Grevey, Mother
(b) Address 1726 N. ~~[illegible]~~ Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by reg.) MAY 10 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944, at 10 20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7, 1944, to May 8 1944, and that I last saw him alive on May 8, 1944

Immediate cause of death Acute Cardiac Dilatation — Duration —
Due to Chronic Myocarditis — ?
Glomerular Nephritis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner, M.D.
Address 2401 N. North Ave. Date signed 5/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2224 W. North Ave: BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17041

CERTIFICATE OF DEATH

937 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 Huntington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 1
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Vincenzo Pollifrone

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. 219-01-0323

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1866

8. AGE: Years	Months	Days	If less than one day
78	2 3	27	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired Lamplighter
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Nicholas Detorie
(b) Address 2225 Huntington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Saint Vincent's
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) Date received by local registrar MAY 10 1944 (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944, to May 7 1944 and that I last saw h.im alive on May 6 1944

Immediate cause of death	Duration
Myocardial Insufficiency	2 3 days
Due to Arterio-Sclerosis	4 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Phillips, M. D.
Address 2224 W. North Ave Date signed 5/8/44

17042

YA-87275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. G 17042

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Delto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Irving Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1874

8. AGE: Years 69 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Jewelry repair & Optician

11. Industry or business Self

FATHER
12. Name Webster Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Ridgley
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof May 11 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md

18 (a) Funeral director Minnie Cook Sayler
(b) Address 1600 W. North Ave.

19 (a) (b)

MAY 10 1944

Registrar

Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7 19 44 at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 19 44 to 5-7 19 44.
and that I last saw him alive on 5-7 19 44.

Immediate cause of death	Duration
Bronchopneumonia	3da
Due to Intestinal Obstruction	8wks
Due to Carcinoma Colon	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-4-44

Major findings of operation: Ca Colon

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Gotts M.D.

Address Balto City Hosp Date signed 5-9-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17043 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 E. Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
12. Name -
13. Birthplace Lith

MOTHER
14. Maiden Name Sarah -
15. Birthplace Lith

16 (a) Informant Mat Berman
(b) Address 2213 E. Fairmount Ave

17 (a) Burial (b) Date thereof 5-10-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Adas Israel Cem
Location North Forest Park Belman Hill Rd

18 (a) Funeral director Jack Levins Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9-44 19 , at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4th 1944 to May 9th 1944, and that I last saw her alive on May 9th 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Cardio Vascular	3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature H. J. Lankenau M. D.

Address 100 N. Milton Date signed 5/10/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17044 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2716 Reistertown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2716 Reistertown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Karnoff

3 (b) If veteran, name war

3 (c) Social Security Account No. 764-12-5030

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Watch maker

11. Industry or business

MOTHER / FATHER

12. Name Isaac

13. Birthplace Russia

14. Maiden Name Mingie

15. Birthplace Russia

16 (a) Informant Rene Karnoff

(b) Address 2716 Reis. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-44 (month) (day) (year)

(c) Cemetery or crematory Adas Israel

Location North Point & Herman Hill Rd

18 (a) Funeral director Pace Harvey Inc Clinton Williams, M.D.

(b) Address 1439 E. Baltimore St

19 MAY 10 1944 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9-44 19 , at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to May 9 1944, and that I last saw h[illegible] alive on 5-9-1944.

Immediate cause of death Myocardial Insufficiency 1 week — Duration

Due to Coronary Thrombosis 1 week

Due to Coronary thrombosis 1st attack 1937

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jack Cohen

Address 1804 Eutaw Place Date signed 5/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

17045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G 17045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. 40th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-8039

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Seaboard North Carolina (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER
12. Name Louis Faison
13. Birthplace North Carolina

MOTHER
14. Maiden Name India Lane
15. Birthplace North Carolina

16 (a) Informant Ethel Stokes (sister)
(b) Address 1508 Tracton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10 1943 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port

18 (a) Funeral director Wm. Brooks
(b) Address 1463 N. Carey St

19 MAY 10 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1943, at 11:35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wounds of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 5, 1943 at 10:55 P.M.
(b) Where did injury occur? 103 W. 20th St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Stabbed during altercation.

23. Signature Dr. L. Wolfenstein M.D.
Medical Examiner.
Date signed May 6, 1943

7046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17046

Registered No. 1040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Boston St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Karen Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1943

8. AGE: Years | Months: 6 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER — 12. Name: Edward L. Hughes
13. Birthplace: Balto. Md.

MOTHER — 14. Maiden Name: Mary B. Rehak
15. Birthplace: Balto. Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location: Balto. City

18 (a) Funeral director: John M. Welsh
(b) Address: 40 S. Chester Street

19 (Date received by Registrar) MAY 10 1944 (Signature of Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1944 at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....; and that I last saw h.... alive on ....19....

Immediate cause of death	Duration
Not established	
Due to Upper respiratory infection	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation: Autopsy 5/9/44
of autopsy: Staphylococcus aureus septicemia, loss of blood.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Leonard Joel Koenig M.D.
Address Johns Hopkins Hosp Date signed 5-9-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write

VS 150 In other Wellcome by Homer J. Wessels, M.D.

17047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

G 17047

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 E Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-12-1883

8. AGE: Years 61 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER 12. Name Henry Hawkins
13. Birthplace Md

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Charles Williams
(b) Address 1134 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

MAY 10 1944 [illegible] Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-43 19__ to 5-8-44 19__, and that I last saw h.er alive on 5-6-44 19__

Immediate cause of death: Hypertension Cardio Renal disease — Duration: 8 Mo

Due to:

Due to:

Other Conditions: Hemorrhoids
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 W E 23rd Date signed 5-9-44

correct age is especially important. Physicians: please write the

17048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

730

Registered No. G 17048

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 S.Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 S.Highland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte M.Schulka

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	D

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.28,1874

8. AGE: Years	Months	Days	If less than one day
70	2	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline
15. Birthplace Germany

16 (a) Informant Wm.E.Postcher
(b) Address 1005 S.Highland Ave

17 (a) Burial (b) Date thereof 5/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway

MAY 10 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to May 8 1944, and that I last saw her alive on May 7 1944.

Immediate cause of death — Duration

Pernicious Anaemia

Due to from history - over four years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan S. Barnham M. D.
Address 3139 E. Baltimore St. Date signed May 9 1944

049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 937

G 17049
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 N. Broadway (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Charles Figoldinger

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife MARGARET L. AMGRINE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1881

8. AGE: Years 63 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation News Paper Route

11. Industry or business

FATHER 12. Name Herman Figoldinger
13. Birthplace BALTO MD

MOTHER 14. Maiden Name Katherine -
15. Birthplace Germany

16 (a) Informant Charles H Elgin
(b) Address 3203 Cheeley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 11 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave.

18 (a) Funeral director Clarence F. Hoffman
(b) Address 639 N. Broadway

(Date received by registrar) MAY 11 1944 (Signature of registrar) Huntington Williams M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1944 at 11 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1944 to 5-8 1944 and that I last saw him alive on 5-8 1944.

Immediate cause of death Cardiac - Respiratory failure | Duration
Due to Arteriosclerotic Heart Disease | ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Musgrave Jr. M. D.
Address 332 E. University Pkwy Date signed 5/8/44

17058

JL - 87704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17050 ✓ 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Delaware Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bortner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anna Kussman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1865

8. AGE: Years 78-78 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Retired R.R.

11. Industry or business

FATHER
12. Name Edward Bortner
13. Birthplace Pa.

MOTHER
14. Maiden Name Julia ?
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Odonnell St

18 (a) Funeral director Blaine F. Hoffman
(b) Address 1639 Broadway
(c) Date received MAY 10 1944 (month) (day) (year) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1944 at 1:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944 to 5/6 1944.
and that I last saw h[illegible] alive on 5/6 1944.

Immediate cause of death Cardiac failure
Due to Arteriosclerotic heart disease

Duration
?

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathews M.D.
Address B.C.H. Date signed 5/6/44

17051

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17051
Registered No.

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 N. Calvert St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hilda B. McCullough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Mr. ____ McCullough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 1901

8. AGE: Years 43 | Months 1 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name William Nutter
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Edith A. Wheaton
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs Edith A. Nutter
(b) Address 2317 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12.1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

MAY 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944 at 5.14 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1944 to May 10 1944, and that I last saw h.CR. alive on May 9 1944.

Immediate cause of death: Cardio - Respiratory failure — Duration

Due to: Carcinoma of sigmoid colon, c metastasis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen [illegible] M. D.
Address Union Memorial Hosp. Date signed 5-10-44

G 17052 ✓ G 17052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1647 Lorman Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernetine Cuffee

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/1908

8. AGE: Years	Months	Days	If less than one day
36	3	13	hr. min.

9. Birthplace Atlanta, Ga. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Lonie Jones
13. Birthplace Atlanta, Ga.

MOTHER
14. Maiden Name Lila Mayfield
15. Birthplace Atlanta, Ga.

16 (a) Informant Jacob Cuffee(Hus).
(b) Address 1647 Lorman Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N.Carrollton Ave.

19 (a) (b)

MAY 10 1944

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1944, at 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1944 to May 6 1944, and that I last saw h. alive on May 6 1944.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Post operative adhesions	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 24
Major findings of operation: Postoperative adhesions
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Eastham M. D.
Address 803 N Fremont Ave

17053 Wodciech Ziomek V G 17053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Cambridge St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Cambridge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Wojciech George Ziomek (Schumann)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Michalina Ziomek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Michael Ziomek
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Michalina Ziomek
(b) Address 2108 Cambridge St

17 (a) Burial (b) Date thereof May 11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowska
(b) Address 930 Fortieth Ave
(c) [illegible] Washington Blvd.

MAY 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death Bronchopneumonia — Duration 7 Days
Myocardial Failure
Due to Asthma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leo L. Kulacki
Address 126 S. Patterson Park Ave Date signed 5/10/44 M. D.

VS 189

17054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G 17054

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 N. Montford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Slaughter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1882

8. AGE: Years	Months	Days	If less than one day
61	6	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business American Oil Lex

FATHER
12. Name Wm. H. Slaughter
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Williamson
15. Birthplace Md.

16 (a) Informant Mr James M. Collins
(b) Address 2624 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11th 1944 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E North Ave Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Date received MAY 10 1944 (b) Registrar Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8th 1944, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 1944 to 5/8 1944, and that I last saw h[illegible] alive on 5/8 1944

Immediate cause of death	Duration
Hypertensive Heart Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wal Bamm
Address 1501 N. Milton Ave Date signed 5/9/44

17055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 46H

Registered No. G 17055

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/29/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 2/29/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County West Palm Beach,
(c) City or town 4720 N. Poinsetta Ave. Fla.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4720 N. Poinsetta Ave. West Palm Beach, Fla.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

Local Addr: 3008 Oramont Ave., Baltimore, Md.

3 (a) FULL NAME ALONZO OSCAR HATFIELD (Lieut. (jg) CG (C.O.))

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary R. Elliott
6 (c) If alive, give age: 34 years
7. Birth date of deceased (mo., day, yr.): Nov. 25, 1903
8. AGE: Years 40 | Months 5 | Days 14 | If less than one day ... hr. ... min.
9. Birthplace: Rockholds, Ky. (Town, county, and state)
10. Usual Occupation: Lieut. (jg)
11. Industry or business: U. S. Coast Guard

FATHER
12. Name: Thomas Hatfield
13. Birthplace: Rockholds, Ky.

MOTHER
14. Maiden Name: Effie Rogers
15. Birthplace: Rockholds, Ky.

16 (a) Informant: Records, U. S. Marine Hosp.
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11-1944 (month) (day) (year)
(c) Cemetery or crematory: Arlington Natl Cem
Location: Arlington Virginia
18 (a) Funeral director: Pfaff & B. M. Walters
(b) Address: 1 A 1 Strieker St.
19 (a) MAY 10 1944 Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH May 9, 1944, at 5:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1944, to 5/9 1944, and that I last saw him alive on May 9, 1944

Immediate cause of death: Hypostatic pneumonia, right lower lobe cell — Duration: 22 days
Due to: Reticulum/sarcoma, retroperitoneal with generalized [illegible] metastasis — 18 mos.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address: Baltimore, Md. Date signed 5/10/44

VS 150

CG-51361

7056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G 17056

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Light St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Nichols

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1869 ?

8. AGE: Years 75 ? Months 2 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Sea food Dealer

11. Industry or business

MOTHER / FATHER

12. Name John Mitchell

13. Birthplace Baltimore Md.

14. Maiden Name Gertrude Linderkugel

15. Birthplace Germany

16 (a) Informant John W. Nichols

(b) Address 1420 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director Flynn & Flanigan

(b) Address 1426 Light St.

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

MAY 10 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 – 1944 at 9:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to May 9 1944 and that I last saw h[illegible] alive on May 9 1944

Immediate cause of death Carcinoma of Pancreas

Duration 4 mos

Due to

Due to

Other Conditions Metastasis to Liver

(Include pregnancy within 3 months of death)

Date of operation February 1944

Major findings of operation: Carcinoma of Pancreas.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.

Address 1125 N. Charles St. Date signed 5/9/44

G 17057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17057 Registered No. 15413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Boyd St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Frank Meadows

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1935

8. AGE: Years 8 | Months 5 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Joseph R. Meadows
13. Birthplace Md

MOTHER
14. Maiden Name Edsie Young
15. Birthplace Md

16 (a) Informant Mrs Jos. R. Meadows
(b) Address 1016 Boyd St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/12/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Road

18 (a) Funeral director John J. Coombs
(b) Address 401 Hilldale St

19 (a) MAY 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 12.07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944, to May 10 1944, and that I last saw him alive on May 10 1944

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Constrictive pericarditis	?
Due to	
Other Conditions Pulmonary Edema Osteomyelitis	Died

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Edward Zinkie M. D.
Address Zinkie Hosp Date signed 5/10/44

28785 4 G 17058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G 17058
Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Gresham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mitchell Gresham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-09

8. AGE: Years	Months	Days	If less than one day
35	1	5	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Elias Boyd
13. Birthplace Va.

MOTHER: 14. Maiden Name Georgie White
15. Birthplace Va

16 (a) Informant seconds
(b) Address JOHNS HOPKINS HOSPITEL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Old Annapolis Rd
18 (a) Funeral director Robert Williams
(b) Address 1575 Mordecai St
19 (a) (b) (Signature of registrar)

MAY 10 1944 Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1943 to May 1944 and that I last saw her alive on May 6th 1944

Immediate cause of death	Duration
Miliary Tuberculosis with Respiratory Failure	72 hrs.
Due to Tuberculous (and Pyogenic) Abscess of Right Hip	1½ yrs.
Due to Tuberculous salpingitis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address 5 W 11 Date signed 5/13

G 17059 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17059 / 131a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please report correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Hogan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Widowed.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 97	—	—	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Allen Hogan
13. Birthplace N.C.

MOTHER
14. Maiden Name unknown
15. Birthplace N.C.

16 (a) Informant Susan Christmon (daughter)
(b) Address 928 N Bond.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10-44 (month, day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Hunt & Wilding
(b) Address 1545 McElderry St

19 (a) (Date received by registrar) (b) Registrar

MAY 10 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1944, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1944 to May 6 1944 and that I last saw h[illegible] alive on May 5 1944.

Immediate cause of death Coronary occlusion — Duration May 6 1944

Due to Arteriosclerosis.

Due to

Other Conditions Chronic Nephritis and Hypertension (Include pregnancy within 3 months of death) — Complications

Date of operation None

Major findings of operations: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph T Young M.D.
Address 1429 E Monument Date signed 5/9/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17060 (Registered No.)

G 17060

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5917 Sefton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5917 Sefton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa M. Kuntzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Augustus A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-1880

8. AGE: Years	Months	Days	If less than one day
63	4	10	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Helen G. Richardson
(b) Address 6112 Glen Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard Lusk
(b) Address 5315 Harford Rd #14

19 (a) (Date rec'd by registrar) (b)

VS MAY 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1944, to May 9 1944, and that I last saw h[illegible] alive on May 9 1944.

Immediate cause of death	Duration
Hypertension and Chronic Renal Disease	4 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 4930 Belair Rd Date signed May 9, 1944

G 17061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17061 / 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Streets
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Winston Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert D. McElroy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-60

8. AGE: Years	Months	Days	If less than one day
83 84	5	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Matthew McElroy
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hunter
15. Birthplace Maryland

16 (a) Informant Mrs. Alvenda Sutherland
(b) Address 700 Winston ave

17 (a) Burial (b) Date thereof 5/11/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North ave

18 (a) Funeral director Lenard J. Buck
(b) Address 5305 Harford Rd. Baltimore, Md.

19 (a) (Date received by Registrar) MAY 10 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1944, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 9 1944 7 P. M.
(b) Where did injury occur? Bath. Apt. - 700 Winston St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fell down stairs in home.

23. Signature J. L. Wallenmeyer M.D.
Medical Examiner.

Date signed May 9, 1944.

G 17062

G 17062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 132

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 E. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony E Costanza

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1919

8. AGE: Years	Months	Days	If less than one day
24	11	10	hr. min.

9. Birthplace Camden N. J. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Edward Costanza
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Spinnato
15. Birthplace Italy

16 (a) Informant Mrs Edward Costanza
(b) Address 1700 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Leonard J. Buck
(b) Address 3305 Harford Rd.

19 (a) MAY 10 1944 Registrar
(Must not be earlier than date of death)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9 1944, at 9:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1944 to 5-9 1944 and that I last saw h.i.m alive on 5-9 1944

Immediate cause of death: Myocardial Failure — Duration: 24 hrs.
Due to: Chronic Pulmonary Disease (Tuberculosis)
Due to:
Other Conditions: Thoracoplasty (rt)
(Include pregnancy within 3 months of death)
Date of operation 4-25-44
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B Klyanowicz M.D.
Address St Josephs Hosp Date signed 6-7-44

Huntington Williams, M.D.

G 17063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17063 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Ellamont Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 89 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Ellamont Street
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Elizabeth Theresa Kathman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Isador G. Kathman
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) March 23, 1855

8. AGE: Years	Months	Days	If less than one day
89	1	15	--hr. ---min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Valentine Edelman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hepp
15. Birthplace Germany

16 (a) Informant Mary B. Kathman
(b) Address 2211 Ellamont Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAY 10 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 180 for Dr. R. L. Benbow by Howard J. Malkin M.D.

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944 at 6.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to May 8 1944 and that I last saw h alive on May 8 1944

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	3 yrs
Due to Myocarditis	2 mos.
Due to	
Other Conditions Fractured left hip not contributed to death (Include pregnancy within 3 months of death)	8 wks.

Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Mar 12, 1944
(c) Where did injury occur? Balto (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury? Fracture of L. Hip from Floor

23. Signature H. J. Van Schaick M.D.
Address 818 Edmondson Ave Date signed 5/9/44

Accident did not contribute to death as far as I can determined

17064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G 17064
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 15
(e) Length of stay in Baltimore (yrs., mos., or days) "?"

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Hilldale ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi Crosby

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: F.
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1912
8. AGE: Years: 32 | Months: — | Days: — | If less than one day: hr. min.
9. Birthplace: South Carolina "?" (Town, county, and state)
10. Usual Occupation: Maid & Housework
11. Industry or business:

FATHER
12. Name: Sol Crosby
13. Birthplace: "?"

MOTHER
14. Maiden Name: Lottie Seldon
15. Birthplace: "?"

16 (a) Informant: Naomi Crosby
(b) Address: 2802 Hilldale Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 10 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

MAY 10 1944 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 7 1944, and that I last saw her alive on May 7 1944.

	Duration
Immediate cause of death: Uremia	
Due to: Hypertensive malignant	
Due to:	
Other Conditions: Rheumatic C.V.D.	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Parker M. D.
Address Receiving Hospital Date signed 5/10/44

correct age is especially important. Physicians: please write the cause or death clearly and legibly.

VS 150

0940

G 17065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17065 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves
(c) Hospital or institution:
St. Agnes V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 Delma Ave. (21)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. McCrea

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Winifred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11 1875

8. AGE: Years	Months	Days	If less than one day
69	2	29	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Pensioner
11. Industry or business

FATHER
12. Name Thomas McCrea
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Coyle
15. Birthplace Pennsylvania

16 (a) Informant Winifred McCrea
(b) Address 1728 Delma Ave Halethorpe

17 (a) Burial, cremation, or removal (b) Date thereof 5/11/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Druid Ridge Cem

18 (a) Funeral director Wilhoyte Co
(b) Address 217 E Saratoga St

MAY 10 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1944, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1944 to 5/10 1944
and that I last saw h[illegible] alive on 5/9 1944
Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Arthur Nordberg M.D.
Address St. Agnes Hosp. Date signed 5/10/44

correct age is especially important. Physicians, please

VS 150

G 17066 G 17066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Streets
(c) Hospital or institution:
Md. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Fleetwood Ave #14
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary A. Knowles

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1875

8. AGE: Years	Months	Days	If less than one day
68	4	29	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Godfrey Theisen
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Wolfensen
15. Birthplace Germany

16 (a) Informant Edward H. Knowles
(b) Address 2007 Fleetwood Ave #14

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 5-12-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Milton Cook Co.
(b) Address 1217 E. Fort Ave.

MAY 10 1944 (Date received by local registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9/1944, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5/1944 to 5/9/1944, and that I last saw her alive on 5/9/1944

Immediate cause of death: Peritonitis — Duration

Due to: Ruptured Viscera

Due to: Strangulated Hernia

Other Conditions: † Bilot. Tube. # CA of Stomach

(Include pregnancy within 3 months of death)

Date of operation 5/9/44

Major findings of operation: † Perforation # CA of stomach ## Strangulated Hernia

of autopsy: Before

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Jones M. D.
Address [illegible] Date signed 5-9

(over)

G 17067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

G 17067 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 Puritan st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Puritan st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Thomas Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Katie Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1871

8. AGE: Years 72 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Special Police

11. Industry or business Pinkerton Construction Co.

FATHER
12. Name Thomas W. Green
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. Rollins
15. Birthplace Balto. Md.

16 (a) Informant Alice Link
(b) Address 730 Puritan st

17 (a) Burial (b) Date thereof 5/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

MAY 10 1944 (Date rec'd by registrar) (b) Frank Livingston Williams, M.D. Registrar

correct age is especially important, and any wilful error, omission or falsification will render the person responsible liable to prosecution.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th 1944, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944 to May 8 1944 and that I last saw him alive on May 6 1944

Immediate cause of death: CEREBRO-VASCULAR ACCIDENT — Duration: April 5th

Due to: ARTERIOSCLEROSIS

Due to: HYPERTENSIVE

Other Conditions: HEART DISEASE
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 848 N. 36th Date signed 5-12-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G 17068 G 17068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Saratoga & Calvert
(b) Street address 1613 E. Lanvale St.
(c) Hospital or institution: Mercy 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wilford E. Martin

3 (b) If veteran, name war –

3 (c) Social Security Account No. 213-20-6919

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1890

8. AGE: Years 54 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business – Pa. R.R.

FATHER 12. Name James Martin

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Annie D. Fallon Fowler

15. Birthplace Baltimore Md.

16 (a) Informant Wilford E. Martin

(b) Address 1613 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)

(c) Cemetery or crematory Balto. "

Location Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

(Date received) 5-10-44 (Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1944, at 7:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944, to May 8 1944, and that I last saw h.f.h. alive on May 8 1944.

Immediate cause of death Shock due to hematemesis

Duration 8 hrs.

Due to Portal Cirrhosis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation –

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Ellsworth Cook Jr. M. D.

Address Mercy Hospital Date signed 5-8-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

V8 150

G 17069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17069 Registered No. 1278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Willow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Overman

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband ~~or wife~~: Henry C. Overman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Mar 1st 1871
8. AGE: Years: 73 | Months: 2 | Days: 8 | If less than one day: hr. min.
9. Birthplace: Hoboken N. J. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Henry Behrens
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara (Unknown)
15. Birthplace: Germany

16 (a) Informant: Howard Overman
(b) Address: 5107 Walther Ave. 14

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/11/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Balto.
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

(Date rec'd by registrar) 5/10/44 (b)

Huntington Williams, M.D.

VS 150

correct age is especially important, physician, please write plainly

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19 44, at 1:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4-44, to 5-8-44, and that I last saw h.. alive on 5-8-44.

Immediate cause of death	Duration
(a) Ruptured Gangrenous Gall Bladder & Abscess	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 8, 1944
Major findings of operation: Ruptured Gall Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. H. Ingram, M. D.
Address Univ. Hospital Date signed 5-9-44

G 17070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17070 Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. East Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas S. Morrison

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sa Wilkie Morrison
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years: About 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Carpenter

FATHER
12. Name: (Unknown) Morrison
13. Birthplace: Scotland

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Margaret Wiclow
(b) Address: 110 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/44 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Extended

18 (a) Funeral director: Williams Bros Inc
(b) Address: 1217 St. Paul St

MAY 10 1944 (Date Filed By Registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1944 to 5/6 1944, and that I last saw h[illegible] alive on 5/1 1944

Immediate cause of death: Cerebral Hemorrhage — Duration:

Due to: Arterio sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Chemlet Flom
Address 321 S. Ewen St. Date signed 5/6/44

VS 150

Use ink. It is especially important. Physicians: please write the causes of death clearly and legibly.

G 17071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 54a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA (b) County
(c) City or town HARRISBURG (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 North st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK D. STIEFFER
3 (b) If veteran, name war
3 (c) Social Security Account No. 716-10-0127

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: NORA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-28-94
8. AGE: Years 50 Months 3 Days 12 If less than one day hr. min.
9. Birthplace PA (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business U.S.

FATHER
12. Name FREDERICK Stieffer
13. Birthplace PA

MOTHER
14. Maiden Name ANNA Stieffler
15. Birthplace PA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 10-44 (month) (day) (year)
(c) Cemetery or crematory East Harrisburg
Location Penna

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

MAY 10 1944 (a) [illegible] (b) [illegible]
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 10 1944, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from APR 24 1944, to MAY 10 1944, and that I last saw him alive on MAY 10 1944.

Immediate cause of death: Carcinoma Tumor - post operative & Uraemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/5/44

Major findings of operation: Bronchial Tumor in right bronchial tube

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Chambers
Address [illegible] Date signed 5/5/44

Write age if specially important. Physicians: please write the causes of death clearly and legibly.

G 17072

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 16

G 17072

PLACE OF DEATH:

City Baltimore

or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Length in above place of death? 10 months

Hospital, institution, or street address where death occurred: KERNAN Hospital

Length in hospital or institution? 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Kent

City or town Chestertown md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

1. (a) FULL NAME NORA REBA THOMAS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Colored	single

(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Date of death (mo., day, yr.) Sept 16, 1941

8. AGE:

Years	Months	Days	If less than one day
2	7	24	..... hrs. ..... min.

9. Birthplace Kent Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name THOMAS THOMAS

13. Birthplace KENT CO. Md.

14. Maiden name MYRTLE BUTLER

15. Birthplace Kent Co. Md.

16. Informant mother Myrtle Butler

17. Address Chestertown, Md.

18. Burial, cremation, or removal. Which?) Burial Date thereof May 14, 1944 (month) (day) (year)

19. Cemetery or crematory Sandy Bottom

20. Location Kent Co Md

21. Funeral director J Willis Wells

22. Address Chestertown, Md

5-10-1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944 at 10:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-28-43 to 5-10- 1944

and that I last saw h. alive on May 10 1944

Immediate cause of death Miliary tuberculosis

DURATION 2 mos.

Due to

Due to

Other conditions Tuberculosis 3 spaces 4 mos

Tuberculosis 3 spaces 12 mos

(Include pregnancy within 3 months of death)

Major findings of operations Tuberculosis of brain

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J Basile M.D.

M. D. or other

Address Kernan Hospital Date signed May 10, 1944

G 17073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17073 Registered No. 110a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Ainsley Richards

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife: Rev. H. F. Richards
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1870

8. AGE: Years	Months	Days	If less than one day
73	5	29 27	hr. min.

9. Birthplace Greenville S.C.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Dr. J. Quincy McDavid
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mary Elizabeth Smith
15. Birthplace South Carolina

16 (a) Informant Rev. H. F. Richards
(b) Address Westminster Md. R.D. # 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1944 (month) (day) (year)
(c) Cemetery or crematory Kindred Corner
Location Westminster, Md.

18 (a) Funeral director H. Bankard Son
(b) Address Westminster, Md.

19 (a) (Date rec'd by registrar) MAY 10 1944 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10/44 19 , at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1944, to 5/10 1944, and that I last saw her alive on 5/10 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to General Debilitation	
Due to	
Other Conditions Chronic Emphysema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rallift Jr. M.D.
Address University Hosp Date signed 5/10/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G 17074 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 679 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 South Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer W. Downey, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1936

8. AGE: Years	Months	Days	If less than one day
7	5	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Elmer W. Downey, Sr.
13. Birthplace Rock Hall, Maryland

MOTHER
14. Maiden Name Molie Grieb
15. Birthplace Baltimore, Maryland

16 (a) Informant Elmer W. Downey, Sr.
(b) Address 703 South Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Avenue Road

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson Street

MAY 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9/44 19 , at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1944 to 5/9 1944
and that I last saw h alive on 5/9 1944

Immediate cause of death: Acute Cardiac Failure — Duration: 1da

Due to: Rheumatic Carditis — 6mos

Due to: Valvular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Lancaster, M.D.
Address 679 Washington Blvd. Date signed 5/10/44

G 17075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

G 17075 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45days
(e) Length of stay in Baltimore (yrs., mos., or days) 61YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 SPRINGHILL AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Walder

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-7349

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61 yrs			hr. min.

9. Birthplace RUSSIA (Town, county and state)
10. Usual Occupation CLOTHING CUTTER
11. Industry or business

FATHER
12. Name WOLFE WALDER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MOLLIE
15. Birthplace RUSSIA

16 (a) Informant MARY WALDER
(b) Address 2705 SPRINGHILL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-11-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO. + CONKLIN ST.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 MAY 11 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9 1944, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~3/23~~ 3/23 1944 to 5/9 1944, and that I last saw h. alive on 5/7 1944

Immediate cause of death resp. cardiac failure — Duration

Due to carcinoma of cervix

Due to operation for removal of carcinoma

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 5/9/44
Major findings of operations carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Lebair M. D.
Address Sinai Hosp Date signed 5/11/44

(OVER)

correct age is especially important. Physicians: please write clearly and legibly.

G 17076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 1202

Registered No. G 17076

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4008 Liberty Hgts. Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME HILDA SINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER — 12. Name Henry Snyder

13. Birthplace New York

MOTHER — 14. Maiden Name Rachel Levy

15. Birthplace Balto., Md.

16 (a) Informant Rachel Singer (Mother)

(b) Address 4008 Liberty Hgts. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-44 (month) (day) (year)

(c) Cemetery or crematory Northern Cem

Location Mt. Israel Cem.

18 (a) Funeral director Jos. Levin Inc

(b) Address 1329 E. Baltimore St.

19 (a) MAY 11 1944 (Date received by registrar) Huntington Hillsboro, Md.

VS 150

correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1944, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1944, to 5/10 1944, and that I last saw h.e. alive on 5/10 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to pneumonia	
Due to perforated duodenal ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/8/44

Major findings of operation: perforated duodenal ulcer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irving Sabelin M. D.

Address Sinai Hospital Date signed 5/11/44

17077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 #87112

Registered No. G 17077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 N. Maryland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine McPhail

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1843

8. AGE: Years 100 | Months -7- | Days -2- | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name William McPhail (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Ord (d)
15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12/44 (month) (day) (year)
(c) Cemetery or crematory Greenmt.
Location North ave & Greenmt ave

18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1940 Eutaw Place

MAY 11 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1944, at 1:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944 to 5-10 1944, and that I last saw h[illegible] alive on 5-10 1944

Immediate cause of death: Bronchopneumonia — Duration: 4 Da

Due to: Carcinoma of Breast — Duration: ?

Due to: with Metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: No

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald A. Lebb M. D.
Address Balto City Hosp Date signed 5-10-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17078 453783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G 17078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander P. Conradt

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-70

8. AGE: Years	Months	Days	If less than one day
73	9	10	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business F.A. Davis Found

FATHER
12. Name George Conradt
13. Birthplace Md

MOTHER
14. Maiden Name Clara Poulson
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11/44 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave
18 (a) Funeral director John W. Mitchell & Bros
(b) Address 1900 Eutaw Place

MAY 11 1944 Huntington Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1944, at 3:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944, to May 9 1944, and that I last saw H.M. alive on May 9 1944.

Immediate cause of death	Duration
Uremia	
Due to Bilateral hydronephrosis ad hydroureter	
Due to Carcinoma of urinary bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Randall B. Robb
Address Johns Hopkins Hosp Date signed 5/12/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

17079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G 17079
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Loch Raven
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Riley W. Francis

3 (b) If veteran, name war	3 (c) Social Security Account No.
1st World	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19-1887

8. AGE: Years	Months	Days	If less than one day
56	6	20	hr. min.

9. Birthplace Baltimore Co. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Francis
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Williamson
15. Birthplace Maryland

16 (a) Informant Mrs. Mary C. Ward
(b) Address 4928 Belvidere Ave.

17 (a) Burial (b) Date thereof May 12-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

MAY 11 1944
(Date rec'd by registrar) Registrar of Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9- 1944, at 8.35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: Balto. Co.
(a) Date of injury 5-8-44 at 2.30 P M.
(b) Where did injury occur? Glen Arm Rd & Manor Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck a tree Passenger in automobile

23. Signature Homer F. Anderson M.D.
Medical Examiner.
Date signed 5-10-44

VS 151

G 17080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 17080

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 E. Chase St.
(c) Hospital or institution: At Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 E. Chase St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine E. O'Connor

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Francis A. O'Connor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 7, 1876

8. AGE: Years	Months	Days	If less than one day
68	4	2	hr. min.

9. Birthplace England (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Clark
13. Birthplace England

MOTHER
14. Maiden Name Sarah ?
15. Birthplace England

16 (a) Informant Mrs. Kaye L. Daughtery
(b) Address 915 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1944, at 2 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1942 to 5/6 1944, and that I last saw h[illegible] alive on 5/6 1944

Immediate cause of death	Duration
Ch. myocarditis	
Due to Chron. Coronary Sclerosis	
Due to Bronchopneumonia & Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Homeland M.D.
Address 733 Argonne Dr. Date signed 5/10/44

17081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

G 17081
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Avenue
(c) Hospital or institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Springdale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Frances Cowman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-1869

8. AGE: Years 75 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business None

FATHER
12. Name John G. Cowman
13. Birthplace Millersville, Md.

MOTHER
14. Maiden Name Laura Fisher
15. Birthplace Boston, Mass.

16 (a) Informant Mrs. Charles Slagle Jr.
(b) Address 4803 Roland Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Stewart And Mowen Company
(b) Address 105 West North Avenue, Balto. Md.

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D.

MAY 11 1944
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1944, to May 9 1944, and that I last saw her alive on May 9 1944.

Immediate cause of death — Duration

1) Carcinoma of
Due to G. I. Tract - ?
Due to
Other Conditions -

(Include pregnancy within 3 months of death)
Date of operation Sept - 1942 -
Major findings of operation: Cancer
of autopsy: - None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts. Date signed 5/10/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17082 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Southern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura E Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1857

8. AGE: Years 86 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Cecil Co Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Rischal Clark
13. Birthplace Unknown

MOTHER
14. Maiden Name Annie E Pluck
15. Birthplace Unknown

16 (a) Informant Mollie L Clark
(b) Address 3903 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-44 (month) (day) (year)
(c) Cemetery or crematory Elkton Cemetery
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) (b)

MAY 11 1944 Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1944, to 5-9 1944, and that I last saw h[illegible] alive on 5-9- 1944.

Immediate cause of death Cardio Vascular Disease
Due to Senility
Due to
Other Conditions Gastro Enteritis Acute
(Include pregnancy within 3 months of death)

Duration 7 days / 5 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] MD
Address 1901 Eutaw Pl Date signed 5-10-44

G 17083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 17083 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 E. North Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. A. Douglas McComas Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-9629

4. Sex: Male

5. Color or race: White

6 (a) Single, (married) widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Duncan McComas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-1892

8. AGE: Years 52 | Months 1 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Building Manager

11. Industry or business Chas. C. Fulton

FATHER
12. Name Robt. McComas
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillian Watts
15. Birthplace Maryland

16 (a) Informant Mr. A. Douglas McComas, Jr.
(b) Address 1016 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 11 1944 (b) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1944, at 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1944 to 5-10 1944, and that I last saw him alive on 5-10 1944

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to Uremia

Due to ? (Grave)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Neergaard Jr. M. D.
Address 332 E. University Pkwy Date signed 5/10/44

7084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 17084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Leadenhall Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME John Matthews
(b) If veteran, name war none
(c) Social Security Account No. none

4. Sex Male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced unknown
(b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) unknown —
8. AGE: Years 68 Months Days If less than one day hr. min.
9. Birthplace Cambridge —
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

PARENTS

12. Name unknown
13. Birthplace unknown —
14. Maiden Name unknown
15. Birthplace unknown —

16 (a) Informant Carrie Lawrence
(b) Address 813 Leadenhall St.
17 (a) (Burial, cremation, or removal) (b) Date thereof 5 14 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemty
Location Baltimore, Md.
18 (a) Funeral director Walter B. [illegible]
(b) Address 139 W Hamburg Street
19. MAY 11 1944 Huntington W. Va. Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage,
Due to arteriosclerosis.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenhaupt M.D.
Medical Examiner.
Date signed May 9, 1944

085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17085

131a

YA-77292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1, 6, 29
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2335 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1874

8. AGE: Years	Months	Days	If less than one day
70	-	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Maryland

MOTHER
14. Maiden Name Arminta Saunders
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. George W. Hallowell
(b) Address 1631 Druid Hill Ave.

19 MAY 11 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1944, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/7 1944
and that I last saw h[illegible] alive on 5/7 1944.

Immediate cause of death Bronchopneumonia, [illegible] multiple encephalomalacia — Duration ?
Due to A.S.C.V.D.
Due to
Other Conditions Gen. arteriosclerosis; nephrosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Serpas M.D.
Address BCH Date signed 5/8

G 17086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G 17086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 E 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 E 25th
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie M Foster

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Harry L Foster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9 1865

8. AGE: Years	Months	Days	If less than one day
78	7	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Milburn
13. Birthplace Md

MOTHER
14. Maiden Name Dont know
15. Birthplace Md

16 (a) Informant Mrs H F Watts
(b) Address 511 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (b)

MAY 14 1944

VS 188

CORRECT AGE IS ESSENTIAL. Please see that it is entered.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 9 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-1943 to 5-10-1944 and that I last saw her alive on 5-9-1944.

Immediate cause of death: Arteriosclerotic cardio-renal disease — Duration

Due to

Due to

Other Conditions Chr. cholecystitis & cholelithiasis — 1½ yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rob B. Sybert M. D.
Address 801 Hartford Bldg Date signed 5-10-44

G 17087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 17087 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Chesterfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry F. Bush

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie L Bush
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug 23-1876

8. AGE: Years	Months	Days	If less than one day
67	8	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation C & P Wire Chief
11. Industry or business Retired

FATHER
12. Name William Bush
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Md

16 (a) Informant Elsie L. Bush
(b) Address 2603 Chesterfield
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 [illegible]
19 (a) (By registrar) (b) Registrar

JUN 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9. 1944. at 10.0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13-1944 to 5-9-1944 and that I last saw him alive on 5-8-1944.

Immediate cause of death Lymphosarcoma — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Seibert M. D.
Address 7802 Harford Rd Date signed 5-9-44

G 17088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1943

G 17088 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 N. Washington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto Md.
(If outside city or town limits write RURAL and give town)
(d) Street No. 2003 Washington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wealthy Ann Cloutier

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28-1870

8. AGE: Years	Months	Days	If less than one day
74	1	13	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Henry Eloy Cloutier
13. Birthplace Balto Md

MOTHER
14. Maiden Name Magdalene Burnham
15. Birthplace Balto Md

16 (a) Informant Wisdom W. Pehlke
(b) Address Albany N.Y.

17 (a) Burial (b) Date thereof May 13-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Peter Hayes & Son
(b) Address 1 Charles St

19 (a) MAY 1 1944 (b)
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1939 to May 10 1944, and that I last saw her alive on May 8, 1944.

Immediate cause of death Pulmonary Embolus — Duration Instantaneous

Due to Arterio-Sclerotic heart disease & fibrillation — 5 yrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature N. B. Herman M. D.
Address 1041 St. Paul St. Date signed 5-11-44

Hurley for Mahoney Mgr

N. B. HERMAN

G 17089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17089 Registered No. 148a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 E. Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 E. Fayette st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Dunn Garnett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert H. Garnett
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) June 29, 1916

8. AGE: Years 27 | Months 10 | Days 11 | If less than one day: hr. min.

9. Birthplace: West, Va. (Town, county, and state)

10. Usual Occupation: Waitress

11. Industry or business

FATHER
12. Name: Thomas Dunn
13. Birthplace: W. Va

MOTHER
14. Maiden Name: Josephine Dixon
15. Birthplace: W. Va

16 (a) Informant: Josephine Dixon
(b) Address: 113 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Brantley ave

19 (a) Date received: MAY 11 1944 Registrar: Hunkyton Williams, MD

VS 180

5-10-44 MEDICAL CERTIFICATION - 1:35 AM

20. DATE OF DEATH ~~May 10~~ 1944, at 1:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

	Duration
Immediate cause of death: Shock- post-hemorrhagic	24 hrs.
Due to: Carcinoma, cervix uteri	2 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger B. Scott M. D.
Address Johns Hopkins Hosp. Date signed 5-10-44

Fill in the cause of death clearly and legibly.

G 17090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17090 Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Kennedy Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. von Lossberg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Edith L. nee Bakewell 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1867

8. AGE: Years	Months	Days	If less than one day
76	7	16	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business Retired

FATHER
12. Name Oscar von Lossberg
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Berg
15. Birthplace Balto. Md

16 (a) Informant Mrs Edith L Von Lossberg
(b) Address 1908 Kennedy ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 44 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location North Ave & Milton

18 (a) Funeral director Harry A. Welker
(b) Address 410 E Edmondson Ave.

19 (a) Kunkleyton Williams M.D. (Physician or coroner)
(b) Date received MAY 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944, to May 7 1944, and that I last saw him alive on May 7 1944

Immediate cause of death Cardiac Insufficiency — Duration

Due to Chr. Nephritis

Due to Appendicitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C Monninger
Address 800 E North Ave Date signed 5/16/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 17091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Springhill Farm.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby boy Viers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-8-44

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl H. Viers
13. Birthplace

MOTHER
14. Maiden Name Lola Dixon
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 11 1944 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-44, at 8-15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8- 1944, to 5-8-1944 and that I last saw him alive on 5-8-1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas D. Luckey M. D.
Address Fr. Sq. Hosp Date signed 5/11/44

VS 3

0943

G 17092

TN. 87742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 17092 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5011 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country England

3 (a) FULL NAME George Bailey

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: LOUISE BAILEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): SEPT. 22 1865 ?

8. AGE: Years 78 ? | Months ?8 | Days 8 | If less than one day: hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation: BOILER MAKER

11. Industry or business: BETH. STEEL CO.

FATHER
12. Name ? UNKNOWN
13. Birthplace ? ENGLAND

MOTHER
14. Maiden Name ? UNKNOWN
15. Birthplace ? ENGLAND

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (" Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 13/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) Date received by Registrar MAY 11 1944 (b) Registrar

VS Tbs

Approved: Hunter for Commissioner, Bureau of Vital Statistics

M.D. 5/10/44

Correct age is especially important. Physician please give.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1944, at 955 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1944 to 5-10 1944 and that I last saw him alive on 5-10 1944.

Immediate cause of death: Fracture of skull c Hemorrhage cerebral — Duration: 11 days
Due to: heart failure
Due to:
Other Conditions: Bronchopneumonia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 26/5
(b) Date of occurrence May 2 1944 at M
(c) Where did injury occur? 5011 Eastern Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury Fall in home

23. Signature Paul Matthews M.D.
Address B.P.H. Date signed 5/10/44

G 17093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G 17093 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3/5
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2158 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward H Duffy EDWARD H. DUFFY

MEDICAL CERTIFICATION

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 218 05 9455
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: UNKNOWN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) MAR. 25 1921

8. AGE: Years	Months	Days	If less than one day
23 ~~yrs~~	1	14	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation SOLDIER
11. Industry or business U.S. ARMY
FATHER 12. Name JOHN H. DUFFY
13. Birthplace CONN.
MOTHER 14. Maiden Name MATTIE ALLEN
15. Birthplace VA.
16 (a) Informant JOHN H. DUFFY (FATHER)
(b) Address 2158 DRUID PARK DRIVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 12/44 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATIONAL
Location FREDERICK ROAD
18 (a) Funeral director Tilly and Zeiler INC
(b) Address 403 E. WOLFE ST
19 (a) (Interred by, cremated by, removed by) (b) Huntington, West Va.

MAY 11 1944

20. DATE OF DEATH May 9, 1944, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/8/44 at 11:40 P.M.
(b) Where did injury occur? 41st St. 300' East of Girard Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Collision of Auto & Bridge
23. Signature H. Z. Wallenweber M.D. Medical Examiner.
Date signed 5-8-44

JO
#87705 G 17094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G 17094 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Crawford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1938

8. AGE: Years	Months	Days	If less than one day
-6-	-2-	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sherman Crawford
13. Birthplace North Carolina

MOTHER
14. Maiden Name Bertha Matthews
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 1 Schroeder St

MAY 17 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1944, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/44 to 5/10/44, and that I last saw h[illegible] alive on 5/10/44.

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh W. Josephs M. D.
Address Balt. City Hosp Date signed 5/14/44

Huntington Williams, M.D.

G 17095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√139 B G 17095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmond & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1054 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lorraine Bull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 6 | 1927

8. AGE: Years	Months	Days	If less than one day
16	5	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Furniture occupation

11. Industry or business

FATHER
12. Name Harold Bull
13. Birthplace Darlington, South Carolina

MOTHER
14. Maiden Name Lola Cauthorne
15. Birthplace Darlington, South Carolina

16 (a) Informant Mother
(b) Address 1054 W. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Wm. Kate F. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Signature of local registrar) Registrar

MAY 11 1944

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944 to May 10 1944 and that I last saw her alive on May 10 1944

Immediate cause of death	Duration
Septicemia — Uremia & Meningitis	
Due to Acute Endometritis	
Due to	
Other Conditions C.C. of Fibroids - Abscess of lung -	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Multiple abscesses of lung - Endometritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Townsend Jr. M. D.
Address University Hospital Date signed 5/10/44

Huntington Williams M.D.

G 17096 ~~Public~~ PROFILI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17096
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4512 Furley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 ~~Kent~~ Furley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME Domenick Profili

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife. Angela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1873

8. AGE: Years	Months	Days	If less than one day
70	7	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Profili
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Petriotti
15. Birthplace Italy

16 (a) Informant Mrs. Dante Profili
(b) Address 4512 Furley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard Merck
(b) Address 5505 [illegible]

19 (a) [illegible] (registrar)

MAY 11 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1944, at 9:40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 30, 1944, to May 10 1944, and that I last saw him alive on May 10, 1944

Immediate cause of death — Duration
Congestive Heart Failure — 1 day
Cerebral Hemorrhage — 41 days
Due to Arteriosclerosis — Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Philibert Artigan M. D.
Address 2942 E. Fayette Street Date signed 5/10/44

G 17097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17097
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3140 Ravenwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3140 Ravenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Wagner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elsie M. Wagner
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb. 31 - 1898

8. AGE: Years	Months	Days	If less than one day
45	76	23	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Martin Wagner
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Elsie M. Wagner
(b) Address 3140 Ravenwood

17 (a) Burial (b) Date thereof 5-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rueck
(b) Address 5305 Harford Rd #14

19 (a) MAY 11 1944 [illegible] Washington Williams, M.D.
(Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1944 to 5/8 1944 and that I last saw him alive on 5/2 1944.

Immediate cause of death Acute Coronary Thrombosis — Duration Sudden

Due to

Due to

Other Conditions Coronary artery sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

? PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Queen B. Clark
Address 7404 Rent Rd Date signed 5/9/44

G 17098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17098 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2805 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Bernhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4260

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1886

8. AGE: Years 58 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Bernhardt
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Russia

16 (a) Informant Freda Bernhardt
(b) Address 2805 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) MAY 11 1944 (Date registered) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944, at 7A. M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1943 to May 11 1944 and that I last saw ... alive on May 10 1944

Immediate cause of death: Coronary Thrombosis — Duration: about 1 yr

Due to: Chronic Myocarditis & Arteriosclerosis — Duration: 10 yrs

Due to: ? — Duration: ?

Other Conditions: Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 2002 E Fayette St Date signed May 11 1944 M.D.

G 17099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8/a

G 17099 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Fawn St, Apt.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Fawn St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1943

8. AGE: Years	Months	Days	If less than one day
	4 5		hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Young
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Pearl Hebb
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Pearl Hebb
(b) Address 612 N. Fawn St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A Hartzfeld
(b) Address 918 Druid Hill Ave
Huntington Williams, M.D.

MAY 11 1944 (Date received) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10-1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumococcus Meningitis

Due to

Other Conditions Upper Respiratory Infection

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mehrlein M.D.
Medical Examiner.
Date signed 5-11-44

Use black ink or typewriter. Physicians: please write the causes of death clearly and legibly.

Spec.—1-15-43—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 17100

17100

CERTIFICATE OF DEATH.

467

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 N. Carey ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Richardson

(a) RESIDENCE NO. 704 N. Carey ST., 16-2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Widowed

5a-If married, widowed or divorced HUSBAND of (or) WIFE of Wilson Richardson

6 DATE OF BIRTH (month, day, and year) May 1, 1895

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	49		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)..... Va.
(State or country)

PARENTS

10 NAME OF FATHER Bushrod Jackson

11 BIRTHPLACE OF FATHER (city or town)..... Va.
(State or country)

12 MAIDEN NAME OF MOTHER Catharine Carter

13 BIRTHPLACE OF MOTHER (city or town)..... Va.
(State or country)

14 Informant Naomi Edmonds
(Address) 724 N. Carey St.

15 Filed MAY 12 1944 19 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1944

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1944, to May 9, 1944.

That I last saw her alive on May 9, 1944,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. mos 22 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Phila. Pa.,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ?

(Signed) W. S. Taylor M. D.

5/10, 1944 (Address) 1522 Ashburton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. View Park Cemetery	5-12-44
20 UNDERTAKER Sam'l H. Chaffinch & Son	ADDRESS 638 N. Eutaw
638 N. Eutaw	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

G 17101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

Registered No. G 17101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 2d & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town ~~Baltimore~~ Forest Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/25/44

8. AGE: Years | Months | Days | If less than one day hr. 50 min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER FATHER

12. Name Mr. John Green

13. Birthplace Balto. Md.

14. Maiden Name Mrs. Dorothy Tucker

15. Birthplace Maryland

16 (a) Informant mother

(b) Address Forest Hill, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

MAY 12 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25 1944, at 1:28 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1944, to 4-25 1944, and that I last saw her alive on 4-25 1944.

Immediate cause of death Cardio - Respir failure — Duration

Due to Asphyxiation

Due to Pre-mature Separation of placenta —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harold J. Stanley M. D.

Address 1017 St. Paul St. Date signed 5-25-44

17102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54B

Registered No. G 17102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 E. Chase st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred W. Adler

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Adler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23rd 1893

8. AGE: Years	Months	Days	If less than one day
50	6	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Painter

FATHER
12. Name Isaac Adler
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Malsea Staples
15. Birthplace Balto. Md.

16 (a) Informant Katherine Adler
(b) Address 1232 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Balto " Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) Huntington Williams M.D. (Signature of the registrar) Registrar

MAY 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1944, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h/me alive on 5/10 19 44.

Immediate cause of death Brain Tumor (Caremoma) — Duration 7

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum, M.D.
Address 1206 E. Preston St. Date signed 5/14/44

17103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G 17103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3816 S. 3rd st - Brooklyn
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 S. 3rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Murphy

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of ~~husband or~~ wife Maria Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd 1864

8. AGE: Years 79 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Building

MOTHER / FATHER
12. Name (Unknown) Murphy
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Everett Murphy
(b) Address 3816 S. 3rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Lutheran
Location Fulton Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAY 12 1944 Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1944, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 11 1944, and that I last saw him alive on May 4 1944.

Immediate cause of death	Duration
uremia	
Due to prostatic obstruction	
Due to Cancer of prostate	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury
23. Signature Philip W. Lupton M.D.
Address 302 Patapsco Ave Date signed 5/11/44

VS 150

G 17104 ✓ G 17104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland USMSTS AMERICAN NAVIGATOR - At Sea
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 52
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ERIC BAXTER

3 (b) If veteran, name war: World War 1 & 2
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Jeanne G. Baxter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-14-95
8. AGE: Years 48 | Months 4 | Days 26 | If less than one day: hr. min.
9. Birthplace New York, N.Y. (Town, county, and state)
10. Usual Occupation Mariner
11. Industry or business U. S. Naval Reserve

FATHER: 12. Name John R. Baxter; 13. Birthplace N. Y.
MOTHER: 14. Maiden Name Minnie E. Knott; 15. Birthplace N. Y.

16 (a) Informant Jeanne Baxter
(b) Address 4 E. 32nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Arlington National Location Va.
18 (a) Funeral director Wm Cook Inc
(b) Address 127 St. Paul St
MAY 12 1944 (Date received by Registrar) (b) Huntington Williams Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 5 A. M. approx

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to May 10 1944, and that I last saw him alive on May 9 1944

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Contributory - Chronic bronchitis emphysema	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Seymour W. Rubin M. D.
Address USMSTS American Navigator Date signed May 10 1944

Approved: Robert Lee Graham M.D. May 10 1944

17105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G 17105 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City Park Heights & Clarks Lane.
(b) Street address Arlington Park Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-29
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Arlington Park Apts. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME MAMIE S. HECHT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Emanuel Hecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1867

8. AGE: Years 76 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Isaac Sycle,
13. Birthplace Germany.

MOTHER
14. Maiden Name Henrietta Newman,
15. Birthplace Germany.

16 (a) Informant Mr. Morton E. Hecht,
(b) Address 3410 Bancroft Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/44. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 MAY 12 1944 [illegible]

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th. 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1920, to May 10 1944, and that I last saw her alive on May 10 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 year
Due to: Arterio Sclerosis — 5 Yrs
Due to:
Other Conditions: Arteritis - Hypertrophy of Prostate — 10 Years
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Erwin E. Mayer M. D.
Address Esplanade Apts. Date signed 5/12/44

Erwin E. Mayer

Physician's or undertaker's statement of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D17106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

D17106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4317 Old York Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4317 Old York Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. E. McIntire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife Owen R. McIntire

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1873

8. AGE: Years 71 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Barnabas Bills

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Agnes Sandfox

15. Birthplace Vermont

16 (a) Informant Mrs. Kendrick McIntire

(b) Address 4317 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Bishop & Sons

(b) Address 1827 N. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1943, to May 10 1944, and that I last saw her alive on May 10 1944

Immediate cause of death	Duration
Cerebral hemorrhage	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence no at M

(c) Where did injury occur? no (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)

(e) Means of injury no

23. Signature [illegible] M. D.

Address 5106 Harford Rd Date signed 5-11-44

G 17107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G 17107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Brentman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Brentman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm J. Purdy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Ora L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1858

8. AGE: Years 85 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Frostburg, Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Carl Murphy
(b) Address Overland Ave. Morgan Pk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1944 (mo.) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George & Holland
(b) Address 1611 Druid Hill Ave.

19 MAY 12 1944 Wm. Wright Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1944, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 19 , to 5/10 1944, and that I last saw him alive on 5/10 1944.

Immediate cause of death Chr. Nephritis & Uremia

Due to Acute Indigestion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy Roberts, M.D.
Address 2139 Druid Hill Ave. Date signed 5/12/44

17108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G 17108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2345 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2345 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MADELINE M. BRYANT

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John A. Bryant, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/1879

8. AGE: Years	Months	Days	If less than one day
64	9	2	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James B. Whittaker
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Lee
15. Birthplace Va.

16 (a) Informant Mr. John A. Bryant, Jr., Son
(b) Address 720 Merton St., Memphis, Tenn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Farnham, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 MAY 12 1944 (Date rec'd by Registrar) (b) Hunter Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1933, to May 10 1944, and that I last saw her alive on May 10 1944.

Immediate cause of death Carcinoma - Stomach - with

Due to generalized metastases abdominal and pulmonary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation February 1943

Major findings of operation: Carcinoma Stomach.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. E. Needs

23. Signature
Address 2314 W. North Ave. Date signed 5/11/44.

17109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

149a

Registered No. C 17109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) Anne Arundel Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Glenburnie
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leona Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Forest Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1910

8. AGE: Years 33 | Months 9 | Days | If less than one day: hr. min.

9. Birthplace N.C. (Town, county or state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Johnny Westry
13. Birthplace N.C.

MOTHER
14. Maiden Name Mattie Taylor
15. Birthplace N.C.

16 (a) Informant Forest Johnson
(b) Address 1215 A & Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location A & Co Md

18 (a) Funeral director Robert E. Wallace
(b) Address 1515 McElderry St

19 Date received by Local Registrar MAY 12 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Exsanguination — Duration

Due to: Laceration cervix

Due to: Post partum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sup p.p. Laceration of cervix

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Forest C. Meade M. D.
Address University Hosp. Date signed May 6, 44

J & L Wollenweber md undertakers

G 17110 — 4 17110 4CB

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 51B

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3509 Edmondson Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 20-7
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: none
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3509 Edmondson Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Augustus P. Miller

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary E. Horan
6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1867

8. AGE: Years	Months	Days	If less than one day
77	3	19	....hr. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: William C. Miller
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Cordelia Price
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mary E. Hogan
(b) Address: 3509 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: North & Greenmount Aves.

18 (a) Funeral director: John D. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 (a) [illegible] 1944 [illegible] Hampton Williams, M.D.
[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1944, at ....M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14, 1944 to May 9, 1944, and that I last saw him alive on May 9, 1944

Immediate cause of death	Duration
Carcinoma of Prostate	
Due to	
Due to	
Other Conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: George A. Kemp, M. D.
Address: 3030 Edmondson Avenue Date signed: 5/10/44

G 17111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 17111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 E. 25th. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 E. 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert L. Emberton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Emberton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1896

8. AGE: Years	Months	Days	If less than one day
47	5	4	hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Glenn L. Martin

FATHER
12. Name George Emberton
13. Birthplace Missouri

MOTHER
14. Maiden Name Lelia Mc Calleum
15. Birthplace Unknown

16 (a) Informant Laura Emberton
(b) Address 762 S. 36th St

17 (a) Removal (b) Date thereof 5-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Maryland

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 St. Paul St.

MAY 12 1944 (b) Huntington Nathanial, Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1944, at 3:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed May 12, 1944

17112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17112 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 2nd Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna A. Stein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1880

8. AGE: Years	Months	Days	If less than one day
64	1	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business American Stores

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Joseph H. Stein
(b) Address 3102 Willoughby Ave

17 (a) Burial (b) Date thereof 5/13/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer ~~Bill Memorial~~
(d) Location ~~Baltimore Md Frederick Rd~~

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd

19 (a) MAY 12 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 10 1944

G 17113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17113 ✓ Registered No. 1220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Clinton St. (If rural give location)
(e) Citizen of foreign country? Naw (Yes or No) If yes, name country

3 (a) FULL NAME Harry C Heinzerling

3 (b) If veteran, name war No

3 (c) Social Security Account No. 215-09-9874

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29-1882

8. AGE: Years 62 | Months 7 | Days 11 | If less than one day 12 hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Cement Salesman

11. Industry or business

FATHER
12. Name August Heinzerling
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Schlemmer
15. Birthplace Balto. Md

16 (a) Informant Elnora J. George
(b) Address 1801 Chilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Mrs. Nus. John W. Teufel & Son
(b) Address 801 W Fayette St

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

MAY 12 1944

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 1944 at 1 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1944 to 5-11 1944 and that I last saw him alive on 5-10 1944

Immediate cause of death: Shock & peritoneal infection.
Due to: Volvulus
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh S. Taylor M.D.
Address 1211 Light St. Date signed 5-11-44

G 17117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G 17117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook and Catons Aves.
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Vogel
3 (b) If veteran, name war
3 (c) Social Security Account No. 2426-37612
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Leona Vogel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 31, 1887
8. AGE: Years 57 Months 1 Days 9 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation B + O.
11. Industry or business
FATHER 12. Name John (dec'd)
13. Birthplace Maryland
MOTHER 14. Maiden Name Anna (dec'd) Seffrich
15. Birthplace Maryland
16 (a) Informant Barbara Vogel
(b) Address 827 N. Potteiger Pl. Apt.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13-44 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Frederick Rd.
18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.
MAY 12 1944 (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1944, at 9 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1944, to 5-10 1944, and that I last saw him alive on 5-10 1944.

Immediate cause of death	Duration
Cerebral embolism	
Due to Rheumatic C-V disease	
Due to	
Other Conditions Thrombotic hemorrhoids (Include pregnancy within 3 months of death)	

Date of operation 5-8-44
Major findings of operation: Thrombotic hemorrhoids
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howard W. Hein M. D.
Address St Agnes Hospital Date signed 5-10-44

G 17115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

Registered No. G 17115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Harford Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hazel Bradford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1944

8. AGE: Years	Months	Days	If less than one day
			3 hr. 35 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Haskel Bradford
13. Birthplace South Carolina

MOTHER
14. Maiden Name Catherine Wilson
15. Birthplace North Carolina

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory L.H.M.S.
Location JOHNS HOPKINS MEDICAL SCHOOL MAY 12 1944

18 (a) Funeral director Commissioner of Health
(b) Address
(c) MAY 12 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at 12 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1944, to May 3 1944, and that I last saw her alive on May 3 1944.

Immediate cause of death	Duration
Intrauterine asphyxia; asphyxia neonatorum; prolapse cord	
Due to Maternal: premature labor; transverse presentation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephan Jr. M. D.
Address Johns Hopkins Hosp. Date signed 5-8-44

0946
0946

G 17116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 17116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: South Balt. Gen. Hosp. Yes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Light St 3927 Fait Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sandra Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-8-44

8. AGE: Years | Months | Days (1) | If less than one day 30 hrs m. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Ernest B. Collins
13. Birthplace Miss

MOTHER 14. Maiden Name Edna Cook
15. Birthplace Alabama

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 12 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 12 1944 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9 1944, at 4:38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1944, to 5-9 1944 and that I last saw her alive on 5-9 1944.

Immediate cause of death	Duration
Anoxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest J. Quest M.D.
Address 1211 Light St Date signed 5-12-44

VS 150

0947

G 17117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58D

✓ G 17117 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4427 Buena Vista Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A.C. Munzert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12, 1942

8. AGE: Years 1 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John A. Munzert
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Betty M. Duncans
15. Birthplace New Jersey

16 (a) Informant John A. Munzert
(b) Address 4427 Buena Vista Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1944 (month) (day) (year)
(c) Cemetery or crematory St. Marys, Hampden
Location Baltimore Md.

18 (a) Funeral director Bugay Funeral Home
(b) Address 3631 Falls Rd.

MAY 12 1944 (b) Huntington Williams M.D.
(Date rec'd by Local Reg.)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944 at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed May 12, 1944.

G 17118 ✓ G 17118 G [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Oldham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

97616

3 (a) FULL NAME Stephen Francis Huszteck

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/21/44

8. AGE: Years	Months	Days	If less than one day
	11	20	hr. min.

9. Birthplace Unable to obtain further information (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Hustzak
13. Birthplace Hudsbeth Md

MOTHER
14. Maiden Name Lucille Hess
15. Birthplace Louisville Kentucky

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5. 12. 44 (month) (day) (year)
(c) Cemetery or crematory Greensboro.
Location Greensboro Md.

18 (a) Funeral director Raymond B. Rawlings
(b) Address Greensboro. Md

MAY 12 1944 registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1944 at 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1944 to 5/11 1944 and that I last saw h[illegible] alive on 5/11 1944

Immediate cause of death Atelectasis
Bilateral, Acute Bronchitis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: As Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address BCH Date signed 5/12

G 17119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 97

G 17119 Registered No.

Every item of information should be carefully supplied. The space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens and Caton Aves.

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3811 Mt. Hope Retreat (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Miss Catherine E. Geiser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 8, 1865

8. AGE: Years 78 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name John Geiser

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Anna Cahill

15. Birthplace Ireland

16 (a) Informant Miss Ella M. Madden

(b) Address 2334 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery

Location Baltimore, Md.

18 (a) Funeral director E Miller Lamoreau

(b) Address 4510 Liberty Heights Ave.

MAY 12 1944 (Date received by registrar) (b) Registrar

VS 160

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/1944, at 10.25 A M

21. I certify that death occurred on the date above stated: that I attended deceased from 5/3/1944 to 5/11/1944, and that I last saw h.. alive on 5/11/1944.

Immediate cause of death Pulmonary Embolus — Duration 8 Days

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/6/44

Major findings of operation: Gangrene Left foot

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. T. Muse M. D.

Address St. Agnes' Hosp. Date signed 5/11/44

G 17120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 R

G 17120 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington, D. C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1353 Montrose St, N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Carmelia Di Genovessi

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Leonard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1876

8. AGE: Years	Months	Days	If less than one day
67	4	17	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Matthew Amato
13. Birthplace Italy

MOTHER
14. Maiden Name Mesa
15. Birthplace Italy

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director S. N. Hines & Co.
(b) Address

19 MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1944, to May 12 1944 and that I last saw h[illegible] alive on 5-12 1944.

Immediate cause of death	Congestive heart failure &
Due to	pneumonia.
Due to	
Other Conditions	Thrombophlebitis (rt Leg)

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 5-12-44

C 17121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

152

Registered No. C 17121

TM. 87874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Woodyear St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jennie Meyers

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: FREDERICK MEYERS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years ? 59 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name GUSTAVE POGGI
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ITALY

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 13/44 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

MAY 13 1944 (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1944, to 5-11 1944, and that I last saw h[illegible] alive on 5-11 1944

Immediate cause of death: Suffocation

Due to: Cellulitis Both Legs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D B Scott M. D.

Address Balto City Hosp Date signed 5-12-44

17122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G 17122 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. "Unknown" or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Barclay street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Barclay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna F. Benes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank J. Benes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1885

8. AGE: Years	Months	Days	If less than one day
58	6	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James Smrcina
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Antonio Bitcha
15. Birthplace Czechoslovakia

16 (a) Informant Mr. Frank J. Benes
(b) Address 1100 Barclay street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert street

19 MAY 13 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944, at 7.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to May 11 1944.
and that I last saw her alive on May 10 1944

Immediate cause of death — Duration
Cancer of Colon — 5/1944
Due to Chr Nephritis — 9/1943
Due to Contracture of Colon — 9/1943
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Williams, Mary Eaton, M.D.
Address 801 Cathedral St. Date signed 5/13/44

G 17123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. G 17123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garrison Blvd. Nursing Home 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 42
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Rosebank Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clorinda West Ahern

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John P. Ahern
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1864

8. AGE: Years 80 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Queen Anne Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James West
13. Birthplace Queen Anne Co., Md.

MOTHER
14. Maiden Name Catherine Vincent
15. Birthplace Queen Anne Co., Md.

16 (a) Informant Mrs. Noah Walker
(b) Address 424 Rosebank Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Millington Cemetery
Location Queen Anne Co., Md.

18 (a) Funeral director H. W. Meads Son
(b) Address 805 N. Calvert St.

MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944, at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 - 1944 to May 11 1944, and that I last saw her alive on May 11 1944.

Immediate cause of death	Duration
Hemiplegia left.	3 days
Due to Arteri Sclerosis	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard H. Warner M. D.
Address 2807 Garrison Blvd Date signed 5-12-44.

17124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17124
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 Gorsuch ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) LIFe

9-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Gorsuch ave. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HELENA B. BELZ

3 (b) If veteran, name war --
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: JOHN H. BELZ
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar. 15- 1879

8. AGE: Years 65 | Months 1 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George Dillehunt
13. Birthplace Maryland

MOTHER
14. Maiden Name Helena Moore
15. Birthplace Maryland

16 (a) Informant
(b) Address 1102 Gorsuch ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1942, to May 10, 1944, and that I last saw h[illegible] alive on May 10 1944.

Immediate cause of death: Diabetes mellitus — Duration: ____

Due to: ____

Due to: ____

Other Conditions: Chronic myocarditis — Duration: 2 yrs

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel A. Wolfe
Address 1331 E. Monument ave. Date signed 5-[illegible]-44

17125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... supplied. Ya... correct age is especially important. Physicians: please wri... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 S. BENTALOU ST.
(c) Hospital or institution:

20-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. BENTALOU ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ross L. Hohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife MINNIE FLECK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 6, 1896

8. AGE: Years	Months	Days	If less than one day
47	5	7	hr. min.

9. Birthplace BALTIMORE COUNTY (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business

FATHER
12. Name Wm. Hohman
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARGARET LOOS
15. Birthplace MARYLAND

16 (a) Informant MRS. ROSS L. HOHMAN
(b) Address 413 S. BENTALOU ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 13, 1944 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FRED'K Rd

18 (a) Funeral director F. B. WIPPERT'S SON
(b) Address 1300 EUTAW PLACE

MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to May 12 1944 and that I last saw h alive on May 12 1944.

Immediate cause of death Coronary Occlusion — Duration acute

Due to

Due to

Other Conditions Scarlet Fever — 7 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon A. Kochman, M.D.
Address 3921 Edmondson Ave Date signed 4/12/44

LEON A. KOCHMAN

G 17126 RINKER ✓ 937 G 17126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3639 Poland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3639 Poland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie M. Rinker.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert L. Rinker.
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1872

8. AGE: Years	Months	Days	If less than one day
71	6	23	hr. min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry E. Beatty
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary E Little
15. Birthplace Virginia

16 (a) Informant Robert L. Rinker
(b) Address 3639 Poland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13/44 (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location Pikesville

18 (a) Funeral director Thomas F. Donovan
(b) 3611 E. Monument St.

19 (a) MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1943 to May 10 1944 and that I last saw h alive on 5/10 1944

Immediate cause of death: arterio & chronic heart — Duration: 4 yrs

Due to: arterio & chronic, — 4 yrs

Due to:

Other Conditions: Mesenteric Embolism — 6 Days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Hall, M.D.
Address 3020 N. Charles Date signed 5/13/44

G 17127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4840 Pimlico Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4840 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura V. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: Walter E Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 8, 1857

8. AGE: Years: 86 | Months: 10 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual Occupation: None.

11. Industry or business

FATHER
12. Name: George England.
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Susan Dunn.
15. Birthplace: Maryland.

16 (a) Informant: May E. Russell
(b) Address: 4840 Pimlico Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 15/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.

18 (a) Funeral director: Edmondson & Donovan
(b) Address: 3615-17 Chestnut Ave

19 MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1944, at 6.20 M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert L. Graham M.D. Medical Examiner.
Date signed: May 11, 1944

17128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert H. Samuels (Samuel)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah S. Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9 1891

8. AGE: Years 53 Months 3 Days 23 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Contractor

FATHER 12. Name Herman Samuel

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Jennie Hecht

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Sarah S. Samuel

(b) Address 932 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/44. (month) (day) (year)

(c) Cemetery or crematory Har Sinai

Location Balto. Md.

18 (a) Funeral director Edward Sonnheim & Son

(b) Address 1902 Eutaw Place

19 (Signature of local registrar) Hunter Williams M.D.

MAY 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1944; at 12:22 M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.

Date signed May 13, 1944.

VS 151

17129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

G 17129
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Joyce Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1885

8. AGE: Years	Months	Days	If less than one day
58	11	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William Joyce
13. Birthplace Ireland

MOTHER
14. Maiden Name Nellie Ford
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Seminary Hill Road

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1314 Light St.

MAY 13 1944 Registrar

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1944, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1943, to 5/9 1944, and that I last saw h[illegible] alive on 5/9 1944.

Immediate cause of death Shock; Duration
Dep. edema; Cirrhosis of liver
Due to Chron. alcoholism; Hemm. C.V.D.
Due to
Other Conditions Syphilis; ascites; arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Calcification of mitral & tricuspid valves; cirrhosis of liver; hemorrhage, gastric ulcer, perforated
of autopsy: [illegible] ca stomach

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Seigman M. D.
Address B C H Date signed 5/12

PHYSICIAN
Underline the cause to which death should be charged statistically.

17130

453733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V30B

Registered No. G 17130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Jenifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-26-40

8. AGE: Years	Months	Days	If less than one day
4	-	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Richard Jenifer
13. Birthplace Md.

MOTHER
14. Maiden Name Etta Case
15. Birthplace Md.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1944 to May 11 1944 and that I last saw h alive on May 11 1944

Immediate cause of death: Juvenile Paresis + Malaria — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Peabody Drevett M.D.
Address Johns Hopkins Hosp Date signed 5/11/44

G 17131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G 17131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmont
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Beryl Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-5076

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Catherine Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1887

8. AGE: Years	Months	Days	If less than one day
56	10	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Shipping clerk

11. Industry or business

FATHER: 12. Name Andrew P Miller
13. Birthplace Baltimore

MOTHER: 14. Maiden Name Mary Meyers
15. Birthplace Baltimore

16 (a) Informant Mrs Catherine Miller
(b) Address 2618 Beryl Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Baltimore

18 (a) Funeral director Philip Henrici Sons
(b) Address 2024 Eutaw Pl

MAY 13 1944 Huntington Williams M.D.
(Date received) (Local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10-1944 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1944 to 5-10-1944, and that I last saw him alive on 5-10-1944.

Immediate cause of death	Duration
Carcinoma of Kidney & metastases	3 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-18-44

Major findings of operation: Mass in liver

of autopsy: Metastasis to ophthalmic lymphatics & lungs

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harrison Retta M. D.
Address Church Home & Hospital Date signed 5-11-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

17132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 17132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Dondorf (DONDORF)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1858

8. AGE: Years 85 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hale
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/44 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore

18 (a) Funeral director Philip Henri & Sons
(b) Address 2024 Eutaw St

MAY 13 1944 Registrar

VS 150

MEDICAL CERTIFICATION 5.309.

20. DATE OF DEATH May 12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944, to May 12 1944, and that I last saw h[illegible] alive on May 12 1944.

Immediate cause of death — Duration
Edema of Lungs — 1 day.
Due to Chronic myocarditis — 3 yrs
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 5/12/44

17133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17133

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1502

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE E. BINNIX

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/25/1860

8. AGE: Years	Months	Days	If less than one day
83	7	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Louis D. Binnix
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellen R. Sticher
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Samuel L. McNeil, Nephew
(b) Address 3706 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1944 at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1-1943 to May 11/1944 and that I last saw him alive on May 11/44

Duration

Principal cause of death: Coronary Thrombosis + Arteriosclerosis — 2 Months

Due to Arteriosclerosis — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry E. Howell
Address 1911 W. Mount Royal Ave. Date signed May 12, 1944

G 17134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 17134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Wicomico
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Wicomico st
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Annie R. Helms

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~: Frank Helms

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/7/1866

8. AGE: Years 77 | Months 6 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name James B. Bokram
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah A. Poole
15. Birthplace Maryland

16 (a) Informant Mary E. Hornberger
(b) Address 1125 Wicomico st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Ambrose Inc
(b) Address 414 N Franklintown Road

19 (a) 5 13 1944 (Date rec'd by registrar) Harrington (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1944 at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 1940 to May 11 1944 and that I last saw her alive on May 11 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury —

23. Signature Harry Hatz, M. D.

Address 517 Scott St. Date signed 5/16/1944

G 17135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) ~~Hospital or~~ institution: Edgewood Nursing Home 17
(d) Length of stay in ~~hospital or~~ inst. (~~yrs., mos., or~~ days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City~~ or town Balto 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 St. Paul st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia S. Boyd

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~ widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~or wife~~: Elmstead Boyd
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 21st 1864
8. AGE: Years 80 | Months 3 | Days 19 | If less than one day hr. min.
9. Birthplace St. Augustine Fla.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

MOTHER / FATHER
12. Name Unknown
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Burr Beacher
(b) Address 1610 St Paul Street
17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/13/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st
MAY 13 1944 (Registrar) Hampton Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1935 to May 1944 and that I last saw h~~e~~r alive on 5-5 944.

Immediate cause of death: Uremic Coma — Duration: 3 Days
Due to: Chronic Nephritis — 5 Years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. W. Peake M. D.
Address 1123 St. Paul Date signed 5-12-44

VS 150

G 17136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore, Md
(c) City or town Essex, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Marquett Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Frederick [redacted] MARTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1887

8. AGE: Years 56 | Months 55 | Days 8 | If less than one day: hr. 0 min. 29

9. Birthplace Baltimore County, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frederick Julius Martz
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Mersenhalder
15. Birthplace Baltimore County

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1944 N. Broadway

19 (a) MAY 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1944, to May 11 1944, and that I last saw him alive on May 11 1944

Immediate cause of death Cardio-respiratory failure — Duration: ?

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Winegartner Jr. M. D.
Address 332 E. University Pkwy Date signed 5/11/44

G 17137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 17137 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1031 N.Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N.Castle St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie L.Henley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.28,1866

8. AGE: Years	Months	Days	If less than one day
77	6 7	13	hr. min.

9. Birthplace Chestertown Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Edwards
13. Birthplace Chestertown Md,

MOTHER
14. Maiden Name Emma Brown
15. Birthplace Chestertown Md.

16 (a) Informant Benjamin L Henley
(b) Address 1031 N.Castle St.

17 (a) Burial (b) Date thereof 5/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (a) MAY 13 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 1130 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1944 to May 10 1944, and that I last saw her alive on May 10 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	8 days
Due to Arteriosclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Lee Hickman
Address 4116 Northern Parkway Date signed 5/11/44
M. D.

17138 BALTIMORE CITY HEALTH DEPARTMENT C 17138
CERTIFICATE OF DEATH 47c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/26/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 2/26/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town West Palm Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 1044 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

12-6

3 (a) FULL NAME WINFRED EDWARD TRIMBLE
Local Add: 3100 Remington Ave. Baltimore, Md.

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. -

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth D. Berg
6 (c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Mar. 11, 1895
8. AGE: Years: 49 Months: 2 Days: 1 If less than one day: hr. min.
9. Birthplace: Bradenton, Fla. (Town, county, and state)
10. Usual Occupation: Captain
11. Industry or business: Army Transport Service

FATHER: 12. Name: Winfred Kenneth Trimble
13. Birthplace: Rockford, Ill.
MOTHER: 14. Maiden Name: Clara Stoody
15. Birthplace: New Phila., Ohio

16 (a) Informant: Records, U.S.Marine Hosp.
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory: Arlington National
Location: Arlington, Va.

18 (a) Funeral director: A. Lee Oder
(b) Address: 4644 York Rd.

19 (a) MAY 13 1944 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH May 12, 1944 at 1:43 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26, 1944 to May 12, 1944 and that I last saw him alive on May 12, 1944.

Immediate cause of death: Bronchiogenic carcinoma of right lung with multiple metastases — Duration: Since 1/1944

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2/29-Excision rt. supra-clavicular node; 3/22, 3/25 & 4/21-Thoracentesis-Removed fluid.

Findings of autopsy: Ca. of rt. lung As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. F. Adkerson M. D.
Address Baltimore, Md. Date signed 5/12/44

ATS-51294

G 17139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town ~~Fullerton~~ (Overlea)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 E. Overlea Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert Kaltenbach

3 (b) If veteran, name war –

3 (c) Social Security Account No. 215-16-6172

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1921

8. AGE: Years 22 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Balto. County, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Air-plane Factory

FATHER
12. Name George Kaltenbach
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna M. Richter
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. George Kaltenbach
(b) Address 135 E. Overlea Ave.

17 (a) Burial (b) Date thereof 5/15/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) MAY 15 1944 (b) Clayton Williams M.D. Registrar
(Registered number)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12- 1944 at 1 30 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions Despondent

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-12-44 at 12.30 P M.
(b) Where did injury occur? 135 E. Overlea Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self inflicted - gunshot wound

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 5-12-44

G 17140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 17140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. #5 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2836 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Svasek.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Albert.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1869.

8. AGE: Years 74 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation housewife at home.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John Svasek
(b) Address 509 N. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer. Location Belair Rd.

18 (a) Funeral director C. E. Lohmeyer
(b) Address 2601 E. Madison, St.

19 MAY 12 1944 Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 44 at 7:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 19 44 to 5/10 19 44 and that I last saw h. alive on 5/10 19 44

Immediate cause of death: Arteriosclerotic heart disease — Duration

Due to

Due to

Other Conditions Chr. Nephritis, Urinary calculus. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul A. Lukato M. D.
Address 1213 Light St. Date signed May 12, 1944

G 17141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G 17141

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1524 Caroline St

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1524 Caroline St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Miss Bessie Tubman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 - 1883

8. AGE: Years	Months	Days	If less than one day
61		1	hr. min.

9. Birthplace Golden Hill Md

(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business St Joseph Hosp

FATHER

12. Name William Tubman

13. Birthplace Golden Hill Md

MOTHER

14. Maiden Name Mary Simmons

15. Birthplace Golden Hill Md

16 (a) Informant Miss Bessie Tubman

(b) Address 4 Eastbrook Ave Pikesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location

18 (a) Funeral director Charles P Powell

(b) Address 2427 Edmondson Ave

19 MAY 13 1944 (Date rec'd by registrar) Huntington Matthews, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 12 1944 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1944 to 5-12 1944 and that I last saw her alive on 5-12 1944.

Immediate cause of death Acute Cardiac Failure. — Duration

Due to Post operative - Gastro-Intestinal Hemorrhage

Due to Hypertensive-Arteriosclerotic Cardio-Vascular Disease

Other Conditions Pyloric Ulcer - Obesity

(Include pregnancy within 3 months of death)

Date of operation 5-11-44

Major findings of operation: Prepyloric Ulcer. Obesity

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

(f) Signature Stanley B. Hammond

Address St Joseph's Hosp Date signed 5-13-44

VS 150

17142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C 17142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 E. 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. 25th, Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard A. Farren

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-05-4953

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Leonard
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Oct. 8th 1896

8. AGE: Years	Months	Days	If less than one day
47	7	4	####### min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Gas & Electric Co

FATHER
12. Name Patrick Farren
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Tougher
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Farren
(b) Address 1620 E. 25th, Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

MAY 13 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12th, 1944, at 10-30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb'y 1 1944, to May 12 1944, and that I last saw him alive on May 12 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Bill Hall M. D.
Address 1631 E. North Ave Date signed 5/13/44

G 17143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 17143 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 Harford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Harford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Denhardt

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles W. Denhardt
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 3rd, 1873

8. AGE: Years 72 | Months 9 | Days 9 | If less than one day ######### min.

9. Birthplace At Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Adam Schoenhals
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Gunderman
15. Birthplace Germany

16 (a) Informant Mrs. Anna Trebes (Daughter)
(b) Address 1831 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15th, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue Balto: Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 MAY 13 1944 (Date received by Registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 th 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1944 to May 12 1944 and that I last saw h— alive on May 11 1944

Immediate cause of death: Chronic Myocarditis — Duration

Due to: Arteriosclerotic Cardiosis — Duration

Due to: Pneumonia Lobular Right Lung — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Wolfe, M.D.
Address 1331 E. North Ave Date signed 5-12-44

17144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17144 Registered No.

YA-85815

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. - 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Clifton Park Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Christopher Willner

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1858

8. AGE: Years	Months	Days	If less than one day
85	5	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer (retired 20 yrs
11. Industry or business Continental Can Co.

FATHER
12. Name John Willner
13. Birthplace Germany

MOTHER
14. Maiden Name Eve Barbara Mehr
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 - 14 - 44 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore MD.

18 (a) Funeral director Henry H. Sander, Sons
(b) Address North Ave. & Broadway

19 MAY 13 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 1944 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1944 to 5-11 1944 and that I last saw h[illegible] alive on 5-11 1944.

Immediate cause of death: Bronchopneumonia — Duration: wk
Due to:
Due to: Fracture Neck of L. Femur — 4½ mo
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-4-44 at 8 P.M.
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Slipped + fell to floor
23. Signature [illegible]
Address Balto City Hosp Date signed 5-M 12-D 44

For Dr. Nathanson & Howard J. Walden, M.D.

G 17145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140 12

G 17145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 Hampden Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Ollie Garrison

3 (b) If veteran, name war ----
3 (c) Social Security Account No. 217-22-1573

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) September 4, 1921

8. AGE: Years	Months	Days	If less than one day
22	8	8	hr. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housekeeping Crane Operator
11. Industry or business: Bethlehem Steel Co.

MOTHER / FATHER
12. Name: Thomas Hicks
13. Birthplace: Kentucky
14. Maiden Name: Ruth Grimm
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1944 (month) (day) (year)
(c) Cemetery or crematory Jessops
Location Cockeysville Md.
18 (a) Funeral director Lauden M. Beverly Sparks, Md.
(b) MAY 16 1944
19 (a) (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944, to May 12 1944, and that I last saw her alive on May 12 1944.

Immediate cause of death: Pylephlebitis
Hepatic Abscesses
Subphrenic Abscess, Rt.
Due to: Peritonitis Generalized
Due to:
Other Conditions: Infected Abortion
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Nicholas J. Eastman M. D.
Address: Johns Hopkins Hospital Date signed 5-13-44

G 17146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17146 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rosie Gray Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-1885

8. AGE: Years 65 | Months 3 | Days 12 | If less than one day: hr. min. 1879

9. Birthplace Marlottsville - Md. (Town, county, and state)

10. Usual Occupation Baxter

11. Industry or business

FATHER
12. Name Marshall Green
13. Birthplace Howard Co. Md

MOTHER
14. Maiden Name Melvina Johnson
15. Birthplace Howard Co. Md

16 (a) Informant Samuel Green
(b) Address 1207 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location W. Wilkins

18 (a) Funeral director Mrs Katie R. Williams
Address 372 N. Belnord Ave

19 (a) MAY 17 1944 (Date rec'd by registrar) (b) Kenneth Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 19 44, at 12:25 P M

21. I certify that I took charge of the remains described above, held an Inquiry + Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Real death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed May 15, 1944.

VS 151

G 17147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17147 Registered No. 170C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(or) Hospital or institution Johns Hopkins Hospital
(c) Length of stay in hospital or inst. (yrs., mos., or days) 5
(d) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 East Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Haywood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10th 1874

8. AGE: Years	Months	Days	If less than one day
50	—	28	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name William H. Haywood

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Ella Johnson

15. Birthplace Essex, Co. Va.

16 (a) Informant Mrs. Savory Haywood

(b) Address 715 N. Edwards St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) (day) 44 (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 332 N. Schroeder St.

19 (a) MAY 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1944, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, hypostatic

Due to Fracture of both tibia and fibula

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 6, 1944 9 P.M. 5-2
(b) Where did injury occur? Orleans Street 35 Ft. East of Front St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Auto.

23. Signature H. L. Williams M.D. Medical Examiner.

Date signed May 9, 1944.

VS 151

G 1714E

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1443 Ward st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) hy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1443 Ward st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-6-1913

8. AGE: Years 30 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and State)

10. Usual Occupation Domestic -

11. Industry or business

FATHER
12. Name Thomas J Commin
13. Birthplace Carrickfergus Ire

MOTHER
14. Maiden Name Martha Lindenberger
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 5-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date received by Registrar)

MAY 14 1944 Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1944, at 8-30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to May 10 1944, and that I last saw h. alive on May 10 1944.

Immediate cause of death	Duration
acute Lobar Pneumonia	4 Dys
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Svaunden M. D.
Address 1222 Lee Date signed 5/11/44

G 17449 ✓ G 17149

G 17149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

952

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Rosedale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph F. Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. 232-22-7455

4. Sex M | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie Ray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Clarksburg W Va (Town, county, and state)

10. Usual Occupation assembly man

11. Industry or business

FATHER: 12. Name Floyd Hall
13. Birthplace W Va

MOTHER: 14. Maiden Name Kathrin
15. Birthplace W Va

16 (a) Informant Lillie Ray Hall
(b) Address 908 Rosedale Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/14/44 (month) (day) (year)

(c) Cemetery or crematory Fairmount W. Va
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) (By registrar) (b) (By registrar)

MAY 15 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944 to May 13, 1944 and that I last saw h. alive on May 13, 1944

Immediate cause of death Congestive Heart failure — Duration

Due to Rheumatic heart disease

Due to

Other Conditions Subacute bacterial endocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dugan

Address Sinai Hosp Date signed 5/15/44

G 17150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 17150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Svazek (SVASEK)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elvira Svazek

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 16, 1875

8. AGE: Years	Months	Days	If less than one day
69 68	10	23	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Cobbler

11. Industry or business

FATHER
12. Name Frank Svazek
13. Birthplace Austria

MOTHER
14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Elvira Svazek
(b) Address 2118 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto. Md

18 (a) Funeral director Frank Brack & Son
(b) Address 900 N. Charles St

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MAY 14 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1944, at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to Probable accidental fall

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 11 1944 at 12:05 P. M. 7/5
(b) Where did injury occur? N.E. corner of Castle and Madison Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No. He was drunk & fell off pavement striking head
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed May 12 1944.

G 17151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17151 Registered No. 120

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 W North Ave
(c) Hospital or institution: 15 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Robert Traub

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Annette Cohen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct, 29, 1902

8. AGE: Years	Months	Days	If less than one day
41	6	14 13	hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business: Show Business

FATHER
12. Name: Harris Traub
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sarah ?
15. Birthplace: Russia

16 (a) Informant: Mrs Annette Traub
(b) Address: 2300 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 14, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Road
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 MAY 14 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

Approved for Dr. H. L. Williams
C. R. Lubinski Insp

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1944 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to May 12 1944 and that I last saw him alive on May 12 1944

Immediate cause of death: Chronic Pulmonary Tuberculosis — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Theodore Cooper M. D.
Address 202 Park Ave Date signed 5/13/44

COOPER

G 17152

JL - 87955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17152 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 h. 15 m.

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3522 Park Heights Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Gurwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Late Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) c 1866

8. AGE: Years	Months	Days	If less than one day
78 ?	?	?	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Harry Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name Tobie ?
15. Birthplace Russia

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 1944 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

(a) (b)

MAY 14 1944 (Date Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1944 at 8.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1944 to 5/12 1944 and that I last saw h.e alive on 5/12 1944.

Immediate cause of death ? Cerebral Thrombosis — Duration ?

Due to Diabetes Mellitus ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Maltne

Address B.C.H. Date signed 5/12/44 M. D.

C 17153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C 17153 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Ulman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40yts

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Bard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Jacob Bard
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Lena Glass
15. Birthplace Russia

16 (a) Informant Joseph Bard
(b) Address 2900 Ulman

17 (a) Burial (b) Date thereof May 14, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

(c) MAY 14 1944 (Date rec'd by registrar) (b) Huntington Willard, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1939 to 5/10 1944, and that I last saw h[illegible] alive on 5/10 1944.

Immediate cause of death Acute Cardiac failure — Duration

Due to Ch. Hypertention

Due to Ch. Myocarditis

Other Conditions Cystoid Hemorrhage (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. L. Hornstein M. D.
Address 733 Augusta St Date signed 5/13/44

G 17154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17154

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Dukeland & Raynor

(b) Street address West Balto Gen Hosp.

(c) Hospital or institution: West Balto Gen. Hosp. 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2601 Elmora Avenue
(If rural give location)

(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Fannie Shapiro

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Late Louis

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business .....

FATHER
12. Name David Jacobs
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel .
15. Birthplace Russia

16 (a) Informant Frank Shapiro

(b) Address 3606 Libertytown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 44 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemet

Location Southern ave

18 (a) Funeral director A. Lawrence & Bros

(b) Address 1124-26 W. North ave

19 (a) 1 1944 (b) [illegible] Registrar

Registered .....

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13 1944 to 5/14 1944 and that I last saw her alive on 5/14 1944

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Arteriosclerosis

Due to Hypertension cardio-vascular disease

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? .....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature Irving J. Taylor

Address West Balto. Gen. Hosp. Date signed M. D. 5/14/44

Dr. Cole

G 17155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 17155

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Copley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Copley Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Freide

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry Freide

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20th 1857

8. AGE: Years	Months	Days	If less than one day
86	5	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Louis Barth
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Fritzleges
15. Birthplace Germany

16 (a) Informant Mr. Carl L. Freide
(b) Address 3408 Copley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15th 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Md.

18 (a) Funeral director Geo. Wilkinson
(b) Address 2503 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

MAY 14 1944

Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May-12 1944 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-1 1944 to May 12 1944, and that I last saw h[illegible] alive on May-11 1944.

Immediate cause of death	Duration
Chronic Myocardial Degeneration with Heart Failure	6 M
Due to Arteriosclerosis	?
Due to Senility	?
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation X

Major findings of operation:

of autopsy: X

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wesley Cole M.D.

Address 1402 Eutaw Place Date signed 5-13-44

Locust Point Road, Md. R.1

G 17156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G 17156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Compton Ave.
(c) Hospital or institution —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 H
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Compton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary E. Boetker (Stevens)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife (Deceased) August F. Boetker | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1882

8. AGE: Years 62 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name Henry Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Roberts
15. Birthplace Md.

16 (a) Informant Mrs. Emma E. Thomas
(b) Address 1004 Compton Ave. (Granddaughter)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1944 (month) (day) (year)
(c) Cemetery or crematory Lehworth Cem.
Location Baltimore, Md.

18 (a) Funeral director W. Howard Evans
(b) Address 1400 E. Chase St. Balto. 39 Md.

MAY 14 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1944 at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944, to May 12 1944, and that I last saw h alive on May 11 44.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Hemiplegia. — 2 days

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature O. B. Willis M. D.

Address 1279 Williams St. Date signed May 12 1944.

G 17157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 17157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 E. PRATT ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 E. PRATT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOLOMON M. POSNER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife SYLVIA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name GERSON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ANNA
15. Birthplace RUSSIA

16 (a) Informant SYLVIA POSNER
(b) Address 1931 E. PRATT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-14-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) Date received by Registrar MAY 14 1944 (b) Registrar Hunter Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14-44 19 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4-1944, to 5-14 1944, and that I last saw h alive on 5-13 1944.

Immediate cause of death: Aortic cardiac dilatation — Duration: 1 hour
Due to: Arteriosclerosis
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation May 1943
Major findings of operation: Adenoma (enucleated) of Kidney
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy M. D.
Address 2322 Eastpoint Place Date signed 5-14-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463992 G 17158 108

G 17158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:
(a). Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Dan James
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-14

8. AGE: Years	Months	Days	If less than one day
29	9	3	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Simon James
13. Birthplace S.C.

MOTHER
14. Maiden Name Mittie Proffer
15. Birthplace S.C.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 5-13-44 (mo.) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pennsylvania Ave
(c) Huntington Williams, M.D.

MAY 14 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 44 at 1.0 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 19 44 to May 11 19 44 and that I last saw h alive on May 11 19 44

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 5 days

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Chartwright M. D.
Address Johns Hopkins Date signed 5-12-44

CARTWRIGHT

G 17159 BALTIMORE CITY HEALTH DEPARTMENT G 17159

CERTIFICATE OF DEATH 167

Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 East Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Herbert Spear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-1926

8. AGE: Years	Months	Days	If less than one day
17	8	-	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Herman Spears
13. Birthplace Md.

MOTHER
14. Maiden Name Jeanette Spears
15. Birthplace Md

16 (a) Informant Jeanette Spears
(b) Address 155 East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location.....

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Bradley Ave

19 MAY 14 1944 (Date rec'd by registrar) [redacted] Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH May 11, 1944, at 1 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-10-44 at 11:30 P. M.
(b) Where did injury occur? 7 May & Forest streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck with ice pick during altercation

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 5-11-44

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17160 Registered No.

G 17160

CERTIFICATE OF DEATH 132

VA-85930

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Constentino Di Carlo

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-0622

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Constance

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1881

8. AGE: Years 62 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER — 12. Name Louis Di Carlo
13. Birthplace Italy

MOTHER — 14. Maiden Name Mary E. Franco
15. Birthplace Italy

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederik Rd. Balt. Md.

18 (a) Funeral director Frank Della Mora
(b) Address 52 N. Morley St.

MAY 16 1944 (a) registrar (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1944, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1944 to 5/12 1944 and that I last saw h[illegible] alive on 5/12 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 3 years

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hatt M. D.

Address B. C. H. Date signed 5/14/44

G 17161

JL - 87050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136 17161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 S. Decker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rita Carlini

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-0864

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1923

8. AGE: Years	Months	Days	If less than one day
20	11	20	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business Brichan Hopkins

FATHER
12. Name James Carlini
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Scandora
15. Birthplace Balto

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St

MAY 10 1944
(Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 1944, at 6.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1944, to 5-13 1944, and that I last saw h[illegible] alive on 5-13 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattei M. D.
Address B.C.H. Date signed 5/14/44

Huntington Milwaukee, Wis

G 17162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G 17162 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. S. Marine Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits write RURAL and give town)
(d) Street No. 5848 Cedar Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dickinson, John Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 - 1892

8. AGE: Years 52 Months 4 Days 6 If less than one day hr. min.

9. Birthplace Wilmington, Del.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Merchant Marine

FATHER: 12. Name William T. Dickinson
13. Birthplace Wilmington, Del

MOTHER: 14. Maiden Name Mary P. Smith
15. Birthplace Easton, Md.

16 (a) Informant Dickinson, John Henry
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-44 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia Pa

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd.

19 MAY 15 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 1944 at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1944, to 5-13 1944, and that I last saw him alive on 5-13 1944.

Immediate cause of death: Cardiac Decompensation — Duration

Due to: Syphilitic Heart Disease

Due to:

Other Conditions: Paralysis Agitans

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry O. Connell

Address U. S. Marine Hospital Date signed 5/14/44

VS 150

453346.

17163

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 17163 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 152 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Adams 6
(c) City or town Littlestown (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 1. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Study

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Wilson Study 6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 7-5-83

8. AGE: Years 60 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Obediah Horemer

13. Birthplace Pa

MOTHER 14. Maiden Name Sarah Meachey

15. Birthplace Pa

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Removal for Burial (Burial, cremation, or removal) (b) Date thereof May 17 1944 (month) (day) (year)

(c) Cemetery or crematory Christ Church Cemetery

Location Near Littlestown Pa.

18 (a) Funeral director J. M. Little & Son

(b) Address Littlestown Pa.

MAY 15 1944 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 7 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to May 14 1944 and that I last saw her alive on May 14 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Hughes Jr. M.D.

Address Johns Hopkins Hospital Date signed 5/16/44

VS 150

G 17164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 17164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] 4013 Liberty Heights
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3930 Edmondson Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John J. Snyder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna C. Lee Jay | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1855

8. AGE: Years 88 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business

FATHER
12. Name John Snyder
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Anna C. Snyder
(b) Address 3930 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location G.A. 60. Md

18 (a) Funeral director Harry H. Tuttle
(b) Address 410 Edmondson Ave

MAY 11 1944 (Date rec'd by registrar) Huntington Williams, Jr

MAY 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11/44, 19, at 615P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1944, to May 11 1944, and that I last saw him alive on May 7 1944.

Immediate cause of death: Apoplexy — Duration: 6 wks
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W R Johnson M. D.
Address 407 Med Arts Date signed 5-14-44

17165 G 17165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1937

8. AGE: Years 6 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Student School #92

11. Industry or business

FATHER
12. Name James M. Chambers
13. Birthplace Md

MOTHER
14. Maiden Name Florence Grimm
15. Birthplace Pa.

16 (a) Informant James M. Chambers
(b) Address 1044 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 MAY 15 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944 at 12 M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/1

(a) Date of injury 5-13-44 at 8 P. M.
(b) Where did injury occur? Jones Falls at foot of East Monument
(c) Did injury occur in home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Drowning

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 5-14-44

17166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 17166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 S. Conkling St
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John R. Dewald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband or~~ wife Elizabeth Dewald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1875

8. AGE: Years 68 Months 109 Days 29 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER 12. Name (Not Known) Dewald

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Charles Dewald

(b) Address 408 N. Bouldin st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/16/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 (a) MAY 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1944, at 1 45 P M

21. I certify that I took charge of the remains described above, held an Injury - Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull & Subdural Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5/11/44 at 6 P.M. A.M.

(b) Where did injury occur? 2935 O'Donnell St

(c) Did injury occur at home, on farm, industrial place, in public place? Above Archway while at work? Yes

(d) Means of injury Scaffold broke while painting

23. Signature Chester F. Sullivan M.D. Medical Examiner.

Date signed 5/13/44

VS 151

17167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17167
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 HARFORD ROAD.
(c) Hospital or institution:
NURSING HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3MONTH
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 HARFORD ROAD
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN RUGGLES.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Timothy Ruggles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1871

8. AGE: Years 72 | Months 8 | Days 27 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James Chaney
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Unknown
15. Birthplace Md.

16 (a) Informant Vernon Ruggles
(b) Address 2337 N. Calvert St.

17 (a) Burial (b) Date thereof 5/16/44
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 MAY 15 1944 Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 12 1944 at 6.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 10 1944 to MAY 12 1944 and that I last saw h ER alive on MAY 12 1944

	Duration
Immediate cause of death: ANGINA PECTORIS MAY 12 1944.	
ARTERIOR SCLEROSIS	1941
Due to: CHRONIC MYOCARDITIS	1944
Due to:	
Other Conditions: DIABETIS MELLITUS	1940

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Edward C. Chanter M. D.
Address 3013 SAINT PAUL STREET Date signed 5.12/4

17168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 17168
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Hollins st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Kontner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Kontner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14 1867

8. AGE: Years	Months	Days	If less than one day
77	1	29	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Steamfitter

FATHER
12. Name Conrad Kontner
13. Birthplace Germany

MOTHER
14. Maiden Name Cecilia Theinert
15. Birthplace Germany

16 (a) Informant Mary Kontner
(b) Address 2016 Hollins st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

MAY 15 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 1944 at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1944 to 5-13 1944, and that I last saw him alive on 5-13 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic C.V.D.	
Due to	
Other Conditions Cerebral vascular accident?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. M. Shipley M. D.
Address University Hosp. Date signed 5-11-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

17169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G 17169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2245 Cedley st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2245 Cedley st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. C. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-3021

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Eliza E. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28th 1889

8. AGE: Years 54 | Months 9 | Days 15 | If less than one day hr. min. 4

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Electricians Helper

11. Industry or business Shodda Ship Yard

FATHER
12. Name James Thomas
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice Reed
15. Birthplace Balto. Md.

16 (a) Informant Eliza E. Thomas
(b) Address 2245 Cedley st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

MAY 15 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS. 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 5/13 1944, and that I last saw him alive on 5/13 1944

Immediate cause of death Carcinoma of stomach — Duration 6 mons

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 30 E. Wilkens ave Date signed 5/15/44

17170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17170 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 Aranah Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 Aranah Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Haschert

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0205

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Lillian Haschert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1891

8. AGE: Years 52 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business Balto. Transit Co.

FATHER
12. Name George Haschert
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Londergan
15. Birthplace Pa.

16 (a) Informant Lillian Haschert
(b) Address 2522 Aranah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St. Huntington Wilmington, Md.

MAY 15 1944 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to May 13 1944, and that I last saw him alive on May 13 1944

Immediate cause of death	Duration
Coronary Thrombosis	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Cahn M.D.

Address 2145 W Balto St Date signed 5/13/44

G 17171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G 17171

JO #87305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1360 Fremont Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Cromshaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1903

8. AGE: Years 40 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Abbot Jones

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Jones

15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

(c) Huntington Williams, M.D. (Signature of registrar)

MAY 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1944 to 5-12 1944 and that I last saw h[illegible] alive on 5-12 1944.

Immediate cause of death	Duration
Carcinoma of breast	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathus M.D.

Address [illegible] Date signed 5/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 17172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G 17172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 W. York St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE (AMNETTA) BEAMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Howard Prudgett
(b) Address 5 W. York St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James A Hagus
(b) Address 1143 Pine St

19 MAY 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at 11 30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 5-17-44

VS 151

JL - 87748 G 17173 BALTIMORE CITY HEALTH DEPARTMENT G 17173

CERTIFICATE OF DEATH

Registered No. 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 W. Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clifton Askew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1910

8. AGE: Years 34 | Months 2 | Days 15 14 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Pressman
11. Industry or business Boltite Rubber Seal Co.,

FATHER
12. Name Henry Askew
13. Birthplace N. C.

MOTHER
14. Maiden Name Sophia Wilson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-44 (month) (day) (year)
(c) Cemetery or crematory Norfork, Va
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Fell St

19 (a) MAY 15 1944 (b) Clayton Williams, Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1944, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1944, to 5/11 1944, and that I last saw h[illegible] alive on 5/11 1944.

Immediate cause of death	Duration
Shock Anemia	7
Due to Stricture of Left ureter	?
c Chronic pyelonephritis L K	?
Due to Pyelonephritis L K	?
Other Conditions Cloudy swelling of kidney & pericarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathna M. D.
Address B. C. H. Date signed 5/12/44

17174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 17174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Hart st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Hart st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Walker

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-2400

4. Sex M.

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mabel Walker

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 5 1888

8. AGE: Years 56 | Months 10 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Anne Arundel Co. Md (Town, county, and state)

10. Usual Occupation Steveadore

11. Industry or business

FATHER
12. Name William Walker
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Jane
15. Birthplace Md.

16 (a) Informant Mabel Walker

(b) Address 637 Hart st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Branch

Location Anne Arundel Co. Md

18 (a) Funeral director Isaac L. Brown & Son

(b) Address 108 W. Mount Royal Ave

19 MAY 15 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1944 to 5/12 1944, and that I last saw h[illegible] alive on 5/12 1944

Immediate cause of death Chronic Myocarditis

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 5/14/44

VS 3

17175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. C 17175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Penna ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Wilson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Daisy

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-12-1896

8. AGE: Years 48 | Months - | Days - | If less than one day ... hr. ... min.

9. Birthplace North Carolina
(Town, county and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name Hattie ?

15. Birthplace

16 (a) Informant Daisy W. Wilson

(b) Address 1112 Penna ave

17 (a) Burial (b) Date thereof 5-15-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

19 (a) 5/15/44 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at 6:45 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to 5/17 1944, and that I last saw h. alive on 5/16 1944

Immediate cause of death Hypostatic Pneumonia Fever — Duration 12 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. F. Hale M.D.

Address Irvington Date signed May 17 1944

G 17176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17176 6

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 768 Tinnard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WAREHIME = Joseph C.

3 (b) If veteran, name war: 1914-19 WW I
3 (c) Social Security Account No. 213-10-0496

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband~~ or wife Anna M. Warehime
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) June 12, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation B Transit Co. motorman
11. Industry or business

FATHER
12. Name Charles Warehime
13. Birthplace Md

MOTHER
14. Maiden Name Mattie GAMBER
15. Birthplace MD

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory NEW U.S. NATL - Balto.
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave. Baltimore, Md.

19 (a) Date received MAY 15 1944 (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to May 12 1944, and that I last saw him alive on 5-12 1944.

Immediate cause of death	Duration
Meningitis	
Due to meningococcus	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp Date signed 5-13

17177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 159

G 17177 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. H. H. 16 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Oakland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Josephine Sieler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.
9. Birthplace: West Balt. Gen Hosp. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Francis J. Sieler
13. Birthplace: Ill.

MOTHER
14. Maiden Name: Mildred Murphy
15. Birthplace: Md.

16 (a) Informant: Mrs. Francis Sieler
(b) Address: 2104 Oakland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave.
18 (a) Funeral director: John J. Ormsby
(b) Address: 1118 Eastern Ave

19 (a) Date received by Local Registrar: MAY 15 1944 (b) Registrar: Huntington Williams, M.D.
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1944, at 5:55 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19.
and that I last saw h alive on 19.

Immediate cause of death: Pulmonary Atelectasis — Duration: 3 days
Due to: Prematurity
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Irving J. Taylor
Address: West Balto Gen Hosp. Date signed 5/14/44 M. D.

G 17178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17178 Registered No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Leyderhaus Hosp.
(b) Street address
(c) Hospital or institution: Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Constance Sokolowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 '33

8. AGE: Years 11 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Alexander Sokolowski
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Petrikevicz
15. Birthplace Balto

16 (a) Informant R Kaye
(b) Address Leyderhaus Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Balto

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) MAY 15 1944 (b) Huntington Wilkinson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944 at 8⁸⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to May 13 1944 and that I last saw h.. alive on May 13 1944

Immediate cause of death Resp. failure — Duration 38 days

Due to Cerebral embolism

due to dyspnea myocarditis

Due to Diphtheria

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye M.D.
Address Leyderhaus Hospital Date signed May 14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 17179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2622 Evergreen Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Evergreen Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET RUPPERT

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry Ruppert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1858

8. AGE: Years 85 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Weissman
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace Germany

16 (a) Informant Mrs. Henry B. Mann
(b) Address 2622 Evergreen Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 Date MAY 15 1944 Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944, at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944 to May 14 1944 and that I last saw ~~her~~ HER alive on May 14 1944.

Immediate cause of death	Duration
Hypertensive Heart Disease	
Due to Essential Hypertension	
Due to	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operations None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawyer M. D.
Address 4808 Harford Rd Date signed 5/14/44

17180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G 17180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Smith Bolton Sem. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Delk

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Delk

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 13, 1910

8. AGE: Years 33 | Months 10 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Smithfield Va
(Town, county, and state)

10. Usual Occupation Chauffeur 2nd Lt.

11. Industry or business Signal C Motor Pool Pfc

FATHER
12. Name Jacob Delk
13. Birthplace Smithfield Va

MOTHER
14. Maiden Name Bessie Bailey
15. Birthplace Smithfield Va

16 (a) Informant Bertha Delk Wife
(b) Address 6442 W Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cemetery
Location Smithfield Va West End

18 (a) Funeral director Joseph A Shields
(b) Address 1629 Mount Street
(Date received by Registrar) MAY 15 1944 Huntington Nathaniel Mgr.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12-1944, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of abdomen
Acute Peritonitis
Due to

Other Conditions Lobar Pneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-2-44 at 1A M.
(b) Where did injury occur? 925 Chase Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5-13-44

17181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 17181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 605 Washington Blvd (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dorthy B Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f		

6 (b) Name of husband or wife J H Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31. 1873

8. AGE: Years	Months	Days	If less than one day
70	11	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House duties
11. Industry or business ✓

MOTHER / FATHER
12. Name Thomas Ballard
13. Birthplace Md.
14. Maiden Name Rosina Turpin
15. Birthplace Md.

16 (a) Informant Rev John L. Ward
(b) Address 655 Washington Boul
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.
18 (a) Funeral director John B. Middendorf Sons
(b) Address 1900 Eutaw Place

MAY 15 1944 (Date rec'd by registrar) (b) Huntington Williams Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14-44 19 , at 7:07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 19 44 to 5-14 19 44 and that I last saw him alive on 5-14 19 44

Immediate cause of death: Cerebro vascular accident — Duration

Due to: arterio sclerotic disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Traynor M. D.
Address Md. Genl. Hosp Date signed

17182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 17182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Bolton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Mace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Edwin T. Mace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/65

8. AGE: Years 78 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Wm. Mills
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Traverse
15. Birthplace Md.

16 (a) Informant Margaurite M. Ewell
(b) Address 1513 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received) MAY 15 1944 (b) Huntington Williams, M.D. Registrar

VS. 189

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to May 13 1944, and that I last saw her alive on 5/12 1944.

Immediate cause of death: Cerebral Thrombosis — Duration 1 hr

Due to: Arterio-Sclerosis — Duration Indefinite

Due to: Hypertension & Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Healy M.D.
Address 1403 Park Ave. Date signed 5/15/44

17183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G 17183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution St. Agnes Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 76 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Ingleside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Eliza Jane Hall

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30. 1859

8. AGE: Years 84 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name B. M. SMYTHE HALL
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELIZABETH TAYLOR HALL
15. Birthplace BALTO. MD.

16 (a) Informant WM. P. HALL
(b) Address 2406 KENOAK ROAD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16. 1944 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3601 FREDERICK AVE.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 2900 EUTAW PLACE

19 (a) Date received by local registrar MAY 15 1944 (b) Thurlby Fox Williams M.D. Registrar

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1944 at 6:01 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944 to 5-14 1944 and that I last saw her alive on 5-14 1944

Immediate cause of death: Hypostatic Pneumonia — Duration:
Due to: Fracture of Right Hip
Due to:
Other Conditions: Decubitus Ulcers Extensive; Hypertensive C.V. Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence February-1944 ? M
(c) Where did injury occur? 908 Ingleside Ave Catons Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? yes
(Specify type of place)
(e) Means of injury A fall in the Home

23. Signature N. E. McGlannan M.D. M. D.
Address St. Agnes Hosp. Date signed

For Stat. Numbers, by Howard J. Walker, M.D. 5/14/44

17184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

Registered No. C 17184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Hawthorne Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Elizabeth C. Codling

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1924

8. AGE: Years 19 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER
12. Name Mr F. L. Codling
13. Birthplace Md

MOTHER
14. Maiden Name Etta L. Lewis
15. Birthplace Md

16 (a) Informant Frank L. Codling
(b) Address 509 Hawthorne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Cemetery
Location Mt Airy Md

18 (a) Funeral director John D. Mitchell Home
(b) Address 1900 Eutaw Place

MAY 15 1944 (Date rec'd by registrar)

19 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1944, at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1944 to 5-14 1944, and that I last saw h alive on 5-14 1944

	Duration
Immediate cause of death: Cardio-Respiratory failure	
Due to: Sub-acute bacterial endocarditis	
Due to:	
Other Conditions: Rheumatic Heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Mungathorpe Jr. M. D.
Address 332 E. University Pkwy Date signed 5/14/44

27-110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G 17185
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 D.

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Swansboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

FULL NAME Melba Kathleen Schubert

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-32

8. AGE: Years 11 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leslie H. Schubert
13. Birthplace Ohio

MOTHER
14. Maiden Name Melba Patton
15. Birthplace Ohio

16 (a) Informant records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17/44 (month) (day) (year)
(c) Cemetery or crematory Sardinia Ohio
Location

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1200 Eutaw Pl. Baltimore Md.

19 (d) MAY 13 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1944 to May 14 1944 and that I last saw h[illegible] alive on May 14 1944

Immediate cause of death: Coronal abscess, Cerebellar tumor — postmortem

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/12/44

Major findings of operation: Cerebellar tumor

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul W. Chambers M. D.

Address Johns Hopkins Hospital Date signed 5/14/44

G 17186

JO #87301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 17186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 Remington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Susie Steward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ?, 1911 ?

8. AGE: Years	Months	Days	If less than one day
33	3 ?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Stokes
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn -

18 (a) Funeral director Sa Brookes
(b) Address 1463 N. Carey st.

19 MAY 15 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1944, at 7:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944, to 5/12 1944, and that I last saw h[illegible] alive on 5/12 1944

Immediate cause of death: Pulmonary TBC — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No crown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Martone M. D.

Address B.C.H. Date signed 5/12/44

17187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 17187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Chesley Ave
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** OSWALD H. GEBLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-03-3095

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maria M. Gebler

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 25th 1887

8. AGE: Years 57 | Months 3 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Iron Worker

11. Industry or business Steel Works

FATHER
12. Name Herman Gebler
13. Birthplace Germany

MOTHER
14. Maiden Name Rosie Walther
15. Birthplace Germany

16 (a) Informant Mrs Maria M. Gebler
(b) Address 107 Chesley ave. Overlea

17 (a) Burial (b) Date thereof 5/16/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Lassahn Funeral Homes
(b) Address 7401 Belair Road

19 (a) MAY 15 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944 at 4 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 5-14-44

VS 151

G 17188

G 17188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 Cliftwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Cliftwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES GERALD TEEVAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1886

8. AGE: Years	Months	Days	If less than one day
57	5	3	hr. min.

9. Birthplace Dunmore, Pa. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business American Brewery

FATHER
12. Name Patrick Teevan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Boland
15. Birthplace Dunmore, Pa.

16 (a) Informant Mrs. Ethel Teevan
(b) Address 2116 Cliftwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date of death) (b) Washington Williams, M.D.
MAY 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944, at 1:00AM

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 3 1943, to May 13, 1944, and that I last saw him alive on May 3, 1944.

Immediate cause of death: Coronary Occlusion — Duration 6 hrs

Due to Arteriosclerosis — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Finegan M. D.
Address 563 E. North Ave. Date signed 5-15-44

G 17189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 17189 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 Bolton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1828 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME ROSA TROEGER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrew Troeger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 10/3/1853

8. AGE: Years	Months	Days	If less than one day
90	7	10	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: William R. Wright
13. Birthplace: England

MOTHER
14. Maiden Name: Susan Woolford
15. Birthplace: Dorchester Co., Md.

16 (a) Informant: Mr. Andrew H. Troeger
(b) Address: 1828 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MAY 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1944 to May 13 1944, and that I last saw h[illegible] alive on May 12 1944.

Immediate cause of death: (1) Senility,
(2) hypertension.
(3) arterio Sclerosis.

Duration

Due to
Due to
Other Conditions Bronchopneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. L. Mentzell M. D.
Address 1730 Linden ave Date signed May 13/44

C 17190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 17190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Lawn View Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Link

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian M. Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/1896

8. AGE: Years 47 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Dudley Verney Co.

FATHER
12. Name George A. Link
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Ann Miller
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Lillian M. Link
(b) Address 3121 Lawn View Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Wm. H. Sidney Sons
(b) Address North & Penna. Ave.

19 (a) 5/15/44 (Date rec'd by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944, at 10:30 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed May 15, 1944.

G 17191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 17191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 Presstman street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Jackson
3 (b) If veteran, name war W. W. –
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Negro
6 (a) Single, married, widowed, divorced. Divorced
6 (b) Name of husband or wife Helen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/2/1887
8. AGE: Years 50 Months 8 Days 10 If less than one day hr. min. 1893
9. Birthplace Rhode Island (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business
FATHER 12. Name Andrew A. Jackson
13. Birthplace N. J.
MOTHER 14. Maiden Name Ella Amos
15. Birthplace Va
16 (a) Informant Elizabeth Bracy
(b) Address 4526 Kenyon Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Md
18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pressman St
19 MAY 15 1944 (Date rec'd by registrar)
Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12-1944 at 3:05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/12/44 at 6 A 12/2 M.
(b) Where did injury occur? 850 N. North ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell down cellar stairs

23. Signature Howard J. Wheeler M.D. Medical Examiner.
Date signed 5/13/44

G 17192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. 17192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. M

6 (b) Name of ~~husband~~ or wife Mary Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1891

8. AGE: Years 52 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Newbern N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Isaac Jones
13. Birthplace N. C

MOTHER 14. Maiden Name Elizabeth Simmons
15. Birthplace N. C

16 (a) Informant Mary Jones
(b) Address 1613 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Sam'l M. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) MAY 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at 1 15 P M

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles J. Pelouze M.D. Medical Examiner.
Date signed 5/12/44

G 17193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G ~~17191~~ Registered No. G 17193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 McCulloh st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noma Hicks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28-1885

8. AGE: Years: 58 | Months: 5 | Days: 14/16 | If less than one day: hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Cleon Grey
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Young
15. Birthplace Md.

16 (a) Informant Richard R. Hicks
(b) Address 2018 McCulloh

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral dir. Sam'l H. Chase Son
(b) Address 638 N. Gilmor St

19 (a) MAY 15 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 Th 1944, at 3 A.M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 5-14-44

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

Registered No. 17194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2046 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George H. Watkins
(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1885

8. AGE: Years 58 | Months 8 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation:

11. Industry or business: At home

FATHER
12. Name: George Wally
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Baumeckat
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. George H. Watkins
(b) Address: 2046 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: John C. Miller
(b) Address: 2435 E. Oliver St

19 (a) ... (Date received by Registrar) (b) ... Registrar

MAY 15 1944

VS 154

MEDICAL CERTIFICATION 63

20. DATE OF DEATH May 13, 1944, at 10 AM

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 5-16-44

G 17195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G 17195

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 871 W. Fairmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 871 W. Fairmont (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ellis Artist
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Minnie Artist
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 5/8/1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	9	27		18 82

9. Birthplace Portsmouth Va.
(Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business Long Shoreman

FATHER
12. Name Not Known
13. Birthplace " " "

MOTHER
14. Maiden Name Not Known
15. Birthplace " " "

16 (a) Informant Florence Briggs
(b) Address 6 L. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) May (day) 15 (year) 1944
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 S Schroeder St

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

MAY 15 1944
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 - 1944 at M

21. I certify that death occurred on the date above stated: that I attended deceased from Feb 8 1944 to May 12 1944 and that I last saw deceased alive on May 12 1944

Immediate cause of death

	Duration
Cerebral Hemorrhage	2 days
Due to Interstitial Nephritis	3 mo
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. T. Lemmon M.D.
Address 562 N. Arlington Ave

17196 | BALTIMORE CITY HEALTH DEPARTMENT | C 17196
CERTIFICATE OF DEATH
Registered No. 45B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Week
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Week

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Thurmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A HAHN

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1904

8. AGE: Years 39 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Thurmont Md (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Arnold A Hahn
13. Birthplace Thurmont Md

MOTHER 14. Maiden Name Sarah A Sweeney
15. Birthplace Thurmont Md

16 (a) Informant Arnold A Hahn
(b) Address Thurmont Md

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 5/17/44

(c) Cemetery or crematory United Brothers
Location Thurmont Md

18 (a) Funeral director H L Eyler Son
(b) Address Thurmont Md

(a) (b)
(Date received by registrar) Registrar

MAY 15 1944
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14 1944, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1944 to 1944, and that I last saw h. alive on 5/14 1944

Immediate cause of death: Medullary Failure — Duration

Due to: Metastatic Ca to brain

Due to: Ca of tongue

Other Conditions: Carcinoma of tonsil

(Include pregnancy within 3 months of death)

Date of operation 5/12/44

Major findings of operation: Sect of 5th nerve &c.

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. K. Thompson M. D.
Address Union Hospital Date signed 5/17

G 17197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 17197

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and name city or town)
(d) Street No. 4017 Penna Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Myrtle Dougherty

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 132-14-3638

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1907

8. AGE: Years	Months	Days	If less than one day: hr.	min.
36	7	17		

9. Birthplace Maine (Town, county, and state)
10. Usual Occupation Curator, Coin Machines
11. Industry or business Repair

FATHER
12. Name John Wheeler
13. Birthplace Great Barrington Mass

MOTHER
14. Maiden Name Emma Spencer
15. Birthplace Great Barrington Mass

16 (a) Informant Thos Dougherty
(b) Address

17 (a) Cremation (b) Date thereof 5/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson Undertaking Co
(b) Address 1214 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 19 1944

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1944, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944, to 5-14 1944, and that I last saw her alive on 5-14 1944.

Immediate cause of death	Duration
Sub arachnoid hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Thompson M. D.
Address Md. Genl Hosp Date signed 5/17/44

G 17198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Wm Thos Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) not known

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Crossroad Dorchester County (Town, county and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Steven Cloal
13. Birthplace Fork neck Dorchester County

MOTHER
14. Maiden Name Susan Lewis
15. Birthplace Cross Road Md.

16 (a) Informant Susan Brown
(b) Address Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 17 44 (month) (day) (year)
(c) Cemetery or crematory Crossroad Cemetery
Location Dorchester County

18 (a) Funeral director Lewis H Bayless
(b) Address 201 Washington St

19 (a) MAY 15 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944, at 5 25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from; natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intermodestus cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williams Weber M.D. (Medical Examiner) Greater 40
Date signed May 15, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1928 17199 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1333 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Christina Hauver

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: John Henry Hauver
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1871

8. AGE: Years	Months	Days	If less than one day
73	3	22	hr. min.

9. Birthplace: Gemania, Pa. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Frederick Braun
13. Birthplace: Germany

MOTHER
14. Maiden Name: Christina Weisner
15. Birthplace: Germany

16 (a) Informant: John Henry Hauver, Jr.
(b) Address: 3121 Woodhome Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn-
Location Elmira, N.Y.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 MAY 15 1944 (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH May 12 1944, 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to May 12 1944, and that I last saw her alive on May 12 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E Gill Hall M. D.
Address 1631 E North Av Date signed 5/13/44

D-17200
45-3697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17200
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Dameron
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Launce
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1909
8. AGE: Years 35 Months Days If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

MOTHER / FATHER
12. Name Con Launce
13. Birthplace Md.
14. Maiden Name Madge Raley
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory Our Lady's Chapel
Location Medley's Neck md.
18 (a) Funeral director M. C. Mattingly Sons
(b) Address Leonardtown, Md.
19 (a) Huntington Williams, M.D. Registrar
MAY 15 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1944 at 5:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1944 to May 14 1944 and that I last saw h[illegible] alive on May 4 1944
Immediate cause of death Leukemia — Duration 4 wks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E. Farber M.D.
Address Johns Hopkins Hosp. Date signed 5/15/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Spec.—1-13-25—M&T—600 Blks.

G 17201

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 17201

CERTIFICATE OF DEATH. ✓159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Harrow Ct. ST., 5th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daul. Kennedy

(a) RESIDENCE No. 1323 Harrow Ct. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	D.

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 10 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 1323 Harrow Ct.
(State or country)

PARENTS

10 NAME OF FATHER Jerry Kennedy

11 BIRTHPLACE OF FATHER (city or town) D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Sally Mae Kennedy

13 BIRTHPLACE OF MOTHER (city or town) D. C.
(State or country)

14 Informant Sally Mae Kennedy
(Address) 323 Harrow Ct.

Filed MAY 15 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1944

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1944, to May 15, 1944, that I last saw him alive on May 14, 1944, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (10 hrs)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. D. Jay Tor M. D.

5/15, 1944 (Address) 1522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY MEDICAL SCHOOL	MAY 15 1944

20 UNDERTAKER Commissioner of Health ADDRESS

0952

CAUSE OF DEATH must be properly certified. BURIAL PERMIT cannot be issued by undertaker unless this certificate is filled out in full. ATTENTION is very important. See instructions on back of certificate.

17202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

17202 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balt. Gen. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Leona Kain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace West. Balt. Gen. Hosp. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Raymond Kain
13. Birthplace Harpers Ferry, W. Virginia

MOTHER
14. Maiden Name Ruth Naomi Cook
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

0951

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10/44 19 to 5/12/44 19, and that I last saw h[illegible] alive on 5/12/44 19.

Immediate cause of death, partial atelectasis Pneumonia Duration
Due to 2 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B N Friedman
Address West Balt Genl Hosp Date signed 5/15/44 M. D.

BALTIMORE CITY HEALTH DEPARTMENT

87282

CERTIFICATE OF DEATH

Registered No. G 17203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Glynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26-1883

8. AGE: Years 60 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Cook & Waiter

11. Industry or business

FATHER
12. Name Michael Glynn (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget O'Connor (D)
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or Crematory UNIVERSITY MEDICAL SCHOOL MAY 15 1944
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 MAY 15 1944 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1944 at 8.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1944 to 5-4 1944 and that I last saw h. alive on 5-4 1944

Immediate cause of death: Pulmonary tuberculosis — Duration: 7

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattus M.D.
Address B.O.H. Date signed 5/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

0950

G 17204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 17204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph William Carroll

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 4- 1890

8. AGE: Years	Months	Days	If less than one day
53	10	9	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business

FATHER
12. Name JOSEPH WILLIAM CARROLL
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name CATHERINE COLLINS
15. Birthplace IRELAND

16 (a) Informant FRANCIS C. CARROLL
(b) Address 2012 E. LANVALE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/16 44 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D. (Registrar)

MAY 15 1944

VS 151

MEDICAL CERTIFICATION 24

20. DATE OF DEATH May 13 1944, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature Howard L. Wollenweber M.D. Medical Examiner.
Date signed 5/15/44

for H. W. L. Wollenweber, by Howard L. Sheets

G 17205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

[redacted] No. 159 G 17205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Sinai Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3226 Sequoia Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marsha Naditch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Premature infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			4 hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Naditch
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Marion Singer
15. Birthplace Philadelphia Pennsylvania

16 (a) Informant Mrs. Marion Naditch
(b) Address 3226 Sequoia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jack Levine
(b) Address 1439 E. Balto St

19 (a) MAY 15 1944 (Date rec'd by Registrar) Harry Williams

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to May 15 1944 and that I last saw her alive on May 15 1944.

Immediate cause of death Prematurity — Duration 4 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
Date of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Raymond B. Wolberg
Address Sinai Hosp Date signed 5/15/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G 17206 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2535 McHenry Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Mc Henry Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Clara May Leverett

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hubert C. Leverett
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): December 12, 1888

8. AGE: Years	Months	Days	If less than one day
55	5	3	hr. min.

9. Birthplace: Chestertown, Kent County, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Amos Kelly
13. Birthplace: Chestertown, Maryland

MOTHER
14. Maiden Name: Hellie Smith
15. Birthplace: Chestertown, Maryland

16 (a) Informant: Amos Franklin Lambert
(b) Address: 2221 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-17-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: George P. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) (b)
MAY 16 1944
VS 186 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944, to May 16 1944, and that I last saw h[illegible] alive on May 14 1944.

Immediate cause of death: Cerebral Embolism — Duration: 4 hrs
Due to: Hypertensive Cardiac Disease
Due to: 1
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Henry Hansmann, M. D.
Address: 2057 McHenry Date signed: May 17 1944

G 17207 ✓ G 17207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W Riley ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Elizabeth Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1859

8. AGE: Years	Months	Days	If less than one day
84	9	14	hr. min.

9. Birthplace Ballard (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name — Riley
13. Birthplace Md

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs H. Meifuth
(b) Address 1613 E. 30th St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 24/44 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Philip Henry Lord
(b) Address 2034 Eutaw Pl

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.
MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 14 1944 at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 22 1944, to 5 - 14 1944, and that I last saw h[im] alive on 5 - 14 1944.

Immediate cause of death Myocardial Failure (Arteriosclerotic Cardiovascular Disease) — Duration 52

Due to

Due to

Other Conditions Pneumonia

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Suprapubic cystostomy + prostatectomy (Include pregnancy within 3 months of death)
Date of operation 3-22-44; 4-14-44
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Stanley B. Klyanowski, M.D.
Address St. Joseph's Hosp. Date signed 5-14-44

17208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17208

Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 75

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 17 - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 McCulloh Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Alice R. Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race wh

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1868

8. AGE: Years 75 Months 6 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John H. Waters

13. Birthplace Md

MOTHER 14. Maiden Name Mary Ann ?

15. Birthplace Md

16 (a) Informant Emma Bright

(b) Address 1224 Eutaw Place Apt. One.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. E. Lafford

(b) Address 1631 Eutaw Pl. Baltimore, Md.

MAY 16 1944
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 1944, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1944, to 5-13 1944, and that I last saw him alive on 5-13 1944.

Immediate cause of death

Due to (Hypothesism Cardio-Vascular Renal Disease)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. B. Butler

Address 2033 Eutaw Pl. Date signed 5/16/44

17209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G 17209 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Division St
(If R.F.D., give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte D. Winder
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jno. Winder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2nd 1882

8. AGE: Years 61 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Blair Downs
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary C. Washington
15. Birthplace Balt. Md

16 (a) Informant Ethel Smith
(b) Address 1117 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Baltimore, Md.

18 (a) Funeral director Jos. Lee H. Holland
(b) Address 1681 Druid Hill Ave

19 (a) (Address of registrar) (b) Hampton Williams M.D.

MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944 at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944 to May 13 1944 and that I last saw her alive on May 13 1944.

Immediate cause of death: Cortex insufficiency — Duration 3 days

Due to Multiple Infarct

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Pelletier M. D.
Address 415 Hamilton Ave Date signed May 17 44

G 17210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 17210 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 N. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Adelaide Longenderfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jacob G. Longenderfer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1859

8. AGE: Years	Months	Days	If less than one day
85	1	1	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lewis Hoff
13. Birthplace United States

MOTHER
14. Maiden Name Amanda Evans
15. Birthplace United States

16 (a) Informant Mrs. Willian Arnold
(b) Address 608 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Sandy Mount Cemetery
Location Carroll County, Md.

18 (a) Funeral director E. Willis Ramsburg
(b) Address 4510 Liberty Heights Ave.

MAY 16 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944 to 5/13 1944 and that I last saw her alive on 5/13 1944.

Immediate cause of death	Duration
General Visceral Failure	3 days
Due to Malnutrition	1 month
Due to Carcinoma of Esophagus & Stricture	3 mos(+)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thurston Williams, M.D.
Address 3629 Edmondson Ave. Date signed 5/15/44

Thurston Williams, M.D.

ROACH

4539437217 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17211 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2463 Dr. Hill ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lynch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-84

8. AGE: Years 60 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER — 12. Name Charles Lynch
13. Birthplace Md.

MOTHER — 14. Maiden Name Eliza Matthews
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Arbutus, Md.

18 (a) Funeral director Charles R. Law
Address 8207 Madison Ave

MAY 16 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 5:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to May 15 1944, and that I last saw him alive on May 15 1944.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Uremia	
Due to: Chronic pyelonephritis + Hypertensive arteriosclerotic Heart disease	
Due to:	
Other Conditions: Lobar pneumonia R. & L. + L. L.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Anatomical Dept. 5/15/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address JHH Date signed 5/15

G 17212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 17212 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3811 Hudson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Hudson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no

3 (a) FULL NAME EDWARD LAWRENCE WEISS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 219-05-1293

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Rahley
6 (c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Nov. 20. 1893

8. AGE: Years 50 | Months 4 5 | Days 22 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Messenger for a Bank

11. Industry or business

FATHER
12. Name: Otto Weiss
13. Birthplace: Germany

MOTHER
14. Maiden Name: Annie Frannie
15. Birthplace: Maryland

16 (a) Informant: Mrs. Mary Weiss
(b) Address: 3811 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May. 18. 1944 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: North Ave. & Broadway.

19 (a) (b) Huntington Williams, M.D. Registrar

MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 8 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944 to May 17 1944 and that I last saw alive on May 17 1944

Immediate cause of death	Duration
Due to Pulmonary Tuberculosis	1942
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rawlings M.D.
Address 601 N Kelworth Date signed 5/18/44

G 17213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G 17213 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 E. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Daniel Maier, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Theresa Maier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1858

8. AGE: Years 86 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual Occupation Retired Dentist
11. Industry or business

FATHER
12. Name Rev. L.D. Maier
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John W. D. Maier, Jr.
(b) Address 1637 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) MAY 16 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH May 15 1944 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1- 1944, to May 15 1944, and that I last saw h[illegible] alive on May 14 1944

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed May 15 44

Huntington Williams, M.D.

G 17214 ✓ G 17214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Willow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olivia Rever

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband William T. Rever

6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) Mar 7 1863

8. AGE: Years 81 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles S. Crookshank.
13. Birthplace Balto.

MOTHER
14. Maiden Name Elizabeth Washington
15. Birthplace Balto

16 (a) Informant Charles B. Rever
(b) Address 3103 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-44 (month) (day) (year)
(c) Cemetery or crematory Brookland Cemetery
Location Balto.

18 (a) Funeral director Wm Cook Jno
(b) Address 1217 St Paul St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.
MAY 16 1944
Approved by C. F. Zahniser M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1944 to 5-15 1944, and that I last saw h[illegible] alive on 5-15 1944

Immediate cause of death: Myocardial Failure (Arteriosclerotic Cardio vascular DISEASE) — Duration: 57da

Due to

Due to

Other Conditions: Pneumonia, Fracture neck - right femur (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/10
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence 3-18-44 at P. M.
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury [illegible]

23. Signature Stanley B Klyanowy M. D.
Address St Joseph's Hosp Date signed 5-15-44

17215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 157 M

G 17215
Registered No.

PLEASE WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md/ (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL W. KULLMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1943

8. AGE: Years	Months	Days	If less than one day
0	6	11	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William
13. Birthplace Clarksburg W. Va.

MOTHER
14. Maiden Name Mary D. Mosca
15. Birthplace Baltimore Md.

16 (a) Informant Mary D. Kullman
(b) Address 4209 E. Lombard St.

17 (a) Burial (b) Date thereof 5/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE

18 (a) Funeral director Clarence E. Wiseman
(b) Address 1459 N. Broadway

MAY 16 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944, to 5-12 1944, and that I last saw h.i.m alive on 5-12 1944.

Immediate cause of death Respiratory Failure — Duration

Due to ~~Coronary Occlusion~~

Due to Coronal Cerebral hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 5-13-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Wirick M. D.

Address Sinai Hosp Date signed 5-13-44

G 17216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G 17216 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 N Cross St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 W Cross St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. GRIFFIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 13th 1883

8. AGE: Years 61 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Mfr Tin Worker

11. Industry or business U.S. Navy Yard

MOTHER / FATHER

12. Name Chas P. Griffin

13. Birthplace Balto Md.

14. Maiden Name Martha Martin

15. Birthplace Balto Md.

16 (a) Informant Effie Griffin

(b) Address 1132 W Cross St

17 (a) Balto Md (Burial, cremation, or removal) Date thereof May 16 44 (month) (day) (year)

(c) Cemetery or crematory Balto Northwood

Location —

18 (a) Funeral director Geo. H. Lyntuch

(b) Address 1254 N. Lynthurst.

19 (a) (Registrar) (b) Huntington Williamsburg, Md

MAY 16 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to May 14 1944, and that I last saw him alive on May 13 1944

Immediate cause of death Odema of Lungs — Duration 2 days

Due to —

Due to —

Other Conditions Bronchial asthma — 5 years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature M. L. Luchtenberg M.D.

Address 2224 Madison ave Date signed May 14 1944

G 17217

JL - 86753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 1721?

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 - 12
(e) Length of stay in Baltimore (yrs., mos., or days): 2mo - 12

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1915 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Baby Boy Solomon

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 2, 1944

8. AGE: Years	Months	Days	If less than one day
	2	12	hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: James Boller
13. Birthplace: ?

MOTHER
14. Maiden Name: Lula Solomon
15. Birthplace: S. C.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1944 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cemetery
Location: B. A. County Md.

18 (a) Funeral director: Mrs. Robt A. Elliott Daughter
(b) Address: 1129 N. Carolina St.

19 (a) (b)

MAY 16 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-14 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1944, to 5-14 1944, and that I last saw him alive on 5-14 1944.

Immediate cause of death	Duration
Pneumonia	2 weeks
Due to	
Due to	over
Other Conditions Prematurity	2½ mos

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Paul Mettee M. D.
Address: B. C. H. Date signed: 5/14/44

G 17218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17218 Registered No. 478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Presbury St,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md , (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Presbury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert H. Smith

3 (b) If veteran, name war ***

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes L. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 1, 1898

8. AGE: Years 46 | Months 2 3 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Mrs Agnes L. Smith

(b) Address 3006 Presbury St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/1944 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Taylor Ave, Parkville.

18 (a) Funeral director Leonard J. Buck

(b) Address 5305 Harford Rd,

19 (a) (Date rec'd by registrar) MAY 16 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13. 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1944 to May 13, 1944 and that I last saw h alive on May 12, 1944.

Immediate cause of death: Carcinoma of right lung — Duration: 3 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert E. Singewald M.D.

Address 1613 E. North Ave Date signed 5/16/44

G 17219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17219 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 N & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hr
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. Duncan St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Poland

3 (a) FULL NAME John Helowicz

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-10-4152

4. Sex: male

5. Color or race: Polish

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mrs Helowicz

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 15, 1888

8. AGE: Years 56 | Months 1 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name: Joseph Helowicz
13. Birthplace: Poland

MOTHER
14. Maiden Name: Marianna Kozlowska
15. Birthplace: Poland

16 (a) Informant: Daughter
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location: Baltimore, Md.

18 (a) Funeral director: George A. Weber
(b) Address: 705 S. Ann street

(b) ... Registrar

MAY 16 1944

VS 150

Huntington Wilkerson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944, to May 15 1944, and that I last saw him alive on May 15 1944

Immediate cause of death: Cardio-Resp. Failure — Duration:
Due to: Arteriosclerotic Heart disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Stephen J. Cannell M.D.
Address: Union Memorial Hosp. Date signed 5-25-44

G 17220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17220

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 W. 36th St.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 W. 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. Dandy

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-5008

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Grace S. Dandy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13-1877

8. AGE: Years	Months	Days	If less than one day
67	2	1	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Joseph Dandy
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Lurem
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Grace S. Dandy
(b) Address 847 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Bygate Funeral Home
(b) Address 3631 Fells Rd

19 MAY 16 1944 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944; at 6.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenweber M.D. Medical Examiner.
Date signed May 15 1944

VS 151

G 17221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G 17221 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Eighth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine V. [redacted] Isaacs

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1942

8. AGE: Years	Months	Days	If less than one day
1	6	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Isaacs
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Krell
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1932 Eighth St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Rutherford & Fairway

18 (a) Funeral director Samuel L. McCarey
(b) Address 1320 E. Fort Ave.

19 (c) Date received by Registrar MAY 18 1944 Huntington Williams #52

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944; at 8:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute gastroenteritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed May 15, 1944

G 17222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G 17222 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Jos. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary J. Ruth (Mary Theresa Ruth)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-07-2484

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George J. Ruth
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 15th, 1872

8. AGE: Years 71 | Months 5 | Days 28 | If less than one day ########## min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Funeral Director
11. Industry or business: Funeral

FATHER
12. Name: Wendell Dippel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Sweitzer
15. Birthplace: Baltimore Md.

16 (a) Informant: Harry J. Dippel (Nephew)
(b) Address: 1737 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location: Edmondson Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) MAY 16 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 — 1944 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28-1944 to 5-13-1944, and that I last saw her alive on 5-13-1944

Immediate cause of death	Duration
Uremia	
Due to: Acute glomerulo-nephritis	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5-6-44
Major findings of operation: Cholelithiasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank L. Vannie, M. D.
Address St. Jos. Hosp. Date signed 5-13-44

G 17228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 17223 Registered No.

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Barrett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Barrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1873

8. AGE: Years 70 | Months 8 | Days 10? | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name George Barrett
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant Mrs Annie Barrett
(b) Address 1315 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

MAY 16 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 14, 1944 19 at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1944 to 3/14 1944.
and that I last saw deceased alive on 3/14 1944.

Immediate cause of death
Cerebral Apoplexy
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
5 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. J. Hatcher
Address 1115 Pa Ave. Date signed 5/16/44

7224 G 17224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Brunt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Brunt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine E. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Chas. H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/18/1880

8. AGE: Years 64 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unobtainable

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Chas. H. Brown

(b) Address 2001 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Geo. A. Kelso

(b) Address 1383 Pleasant

19 (a) MAY 16 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1944 to 5-14 1944, and that I last saw h[illegible] alive on 5-14 1944

Immediate cause of death: Central Asphyxia — Duration

Due to: Paralysis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed

17225 375885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 17225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Presstman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Wooden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-27-12

8. AGE: Years	Months	Days	If less than one day
31	5	16	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

MOTHER / FATHER

12. Name Lewis Wooden

13. Birthplace Md

14. Maiden Name Cora Bold

15. Birthplace Va.

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. G. Kelson

(b) Address 1303 Presstman St.

19 MAY 16 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13 1944 at 10 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1944 to May 13 1944 and that I last saw her alive on May 13 1944

Immediate cause of death	Uremia	Duration
Due to	Hypertensive cardio-vascular disease	
Due to	Arteriolonephrosclerosis	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R Bermingham M. D.

Address 5 N 1A Date signed 5-17-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 32221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1547 N. Gilmor (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1896

8. AGE: Years 47 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name William Stewart
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ammanda Thomas
15. Birthplace Balto. Md.

16 (a) Informant Edith Stewart
(b) Address 1547 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)

(c) Cemetery or crematory St. Peters
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Preston St.

19 MAY 16 1944 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at 11 05 P.M.

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 5-16-44

VS 151

7227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 37227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Ware Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asbury (Ashberry) Marshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lizzie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 1869

8. AGE: Years	Months	Days	If less than one day
54	1	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Singleton Marshall
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Copeland
15. Birthplace Maryland

16 (a) Informant D. S. Marshall
(b) Address 2012 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) MAY 16 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1944, at 9 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frazier M.D.
Medical Examiner.
Date signed May 11, 1944

17228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. G 17228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2320 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 Division St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William N. Reed.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Reed

6 (c) If alive, give age 5-3 years

7. Birth date of deceased (mo., day, yr.) 5-15-1889

8. AGE: Years 54 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Contractor

FATHER
12. Name Wm. N. Reed
13. Birthplace Virginia

MOTHER
14. Maiden Name Matilda Ann ?
15. Birthplace Virginia

16 (a) Informant Mary Reed
(b) Address 2320 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory Emmington
Location Va.

18 (a) Funeral director H. G. Nelson
(b) Address 1303 Priestman St.

19 MAY 16 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14-1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10-1944 to 5-14-1944 and that I last saw h— alive on 5-12-1944

Immediate cause of death: Chronic Valvular Heart Disease — Duration: 4 Mos.
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1612 N. Monument St. (17) Date signed 5-16-44

17229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 1310

C 17229
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Isaiah Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1885

8. AGE: Years 59 54 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Westminster Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Chas Cooper
13. Birthplace Md

MOTHER
14. Maiden Name Rosie Green
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

MAY 16 1944 (Date rec'd by registrar) (Signature) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1944 to May 12 1944 and that I last saw her alive on May 11 1944.

Immediate cause of death: Chr. Cardio-renal disease. — Duration: about 3 mo.
Due to: Unknown
Due to:
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward W. Haines
Address 665 W. Barre Date signed 5/13/44

17230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 17230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 879 W. Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 879 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If ever married, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1939

8. AGE: Years 6 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Sumter. S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Clark
13. Birthplace South Carolina

MOTHER
14. Maiden Name Pearl Rhoads
15. Birthplace South Carolina

16 (a) Informant Frank Clark
(b) Address 879 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 MAY 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenwebber M.D. Acting Medical Examiner.
Date signed

17231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 186a

G 17231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 574 Wilson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Mallicott

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widower

6 (b) Name of husband or wife Grace Mallicott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1889

8. AGE: Years	Months	Days	If less than one day
54	6	28	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wm. Mallicott

13. Birthplace Virginia

MOTHER 14. Maiden Name Fannie Bleford

15. Birthplace Virginia

16 (a) Informant Mary C. Coley

(b) Address 574 Wilson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director Mrs Katye R. Williams

(b) Address 322 N Schroeder St

19 (a) MAY 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13-1944, at 7 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Broken Neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-13-44 at 14/27 A M. 75

(b) Where did injury occur? Alley rear of 564 Mosher St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Fell down ~~Found in alley~~ - Blunt Force

23. Signature Howard J. Madden M.D. Medical Examiner.

Date signed 5/13/44

VS 151

17232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 17232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 myrtle Ave
(c) Hospital or institution.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie T. Bowers

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col	Widow

6 (b) Name of husband or wife Samuel E. Bowers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Hadlesville - Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Ralph Bryor
13. Birthplace King & Queens Co. Va.
MOTHER 14. Maiden Name Ann Crafts
15. Birthplace Richmond Va

16 (a) Informant Jennie Tolson
(b) Address 1229 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-44 (month) (day) (year)
(c) Cemetery or crematory Hadlesville
Location Northumberland Co. Va

18 (a) Funeral director Mrs Katie B. Williams
(b) Address 322 N Schroeder St

19 (c) MAY 16 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 14 - 1944, at 6.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to May 13 1944.
And that I last saw h-r alive on May 13 44

Immediate cause of death
Cardio Vascular Renal Disease — Duration 4
Due to — 1
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. B. Hughes M.D.
Address 132 Lee St. Date of signature May 16 44

17233
JO #37853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17233
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Keidel (Frederick W. Keidel)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jane Ann Keidel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1876

8. AGE: Years 68 | Months -0- | Days 11 | If less than one day hr. min.

9. Birthplace Pennsylvania (Phila.) (Town, county, and state)
10. Usual Occupation Retired Cable Splicer
11. Industry or business C. & P. Tel. Co.

FATHER
12. Name August Keidel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Egan
15. Birthplace Pennsylvania (Phila.)

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) Date received by Local Registrar MAY 16 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1944, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1944 to 5-14 1944, and that I last saw h— alive on 5-14 1944.

Immediate cause of death: Embolism Tuberculosis — Duration: —
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mott M. D.
Address B.C.H. Date signed 5-14-44

17234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17234

Registered No. 97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE BRACKEN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Michael J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/19/1867

8. AGE: Years	Months	Days	If less than one day
77	3	25	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Tracey
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Dunne
15. Birthplace Ireland

16 (a) Informant Mr. Michael J. Bracken
(b) Address 1127 N. Fulton Ave. 7

17 (a) Burial (b) Date thereof 5/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 16 1944 (b) Hester Williams, Reg.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1944, 10:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944 to May 14 1944. and that I last saw h[illegible] alive on May 14 1944.

Immediate cause of death Respiratory failure — Duration

Due to Cardiac failure

Due to Hypertension

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. Sborofsky MD
Address 601 N. Howard St Date signed 5/15/44

Dr Rysavek
17235 Edmondson Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17235
Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 E Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 E Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna F. Raab

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Charles A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1897

8. AGE: Years	Months	Days	If less than one day
46	10	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Vanik
13. Birthplace Hungary

MOTHER
14. Maiden Name Frances
15. Birthplace ?

16 (a) Informant Charles A. Raab
(b) Address 2037 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 1944 (month) (day) (year)
(c) Cemetery or crematory St Joseph
Location Fullerton, Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 247 St Paul St

19 (a) MAY 16 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to May 15 1944 and that I last saw h[illegible] alive on May 15 1944

Immediate cause of death	Duration
Uraemic Coma	5/11/44
Due to Chr Nephritis	10/43
Due to Chr Myocarditis	10/43
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Raysmer M. D.
Address 8014 Kenwood Ave Date signed 5/16/44

G 17236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1649

Registered No. G 17236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 Haubert St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Ludwig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrew Ludwig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1908

8. AGE: Years 35 | Months 6 | Days 16 2/9 | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: Factory worker

11. Industry or business: Hunt Co

FATHER
12. Name: Casper Hanokowicz
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Theresa Pocisk
15. Birthplace: Czechoslovakia

16 (a) Informant: Mrs Rosalie Santos
(b) Address: 2023 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart Cem
Location: German Hill Road

18 (a) Funeral director: John J Fahey & Sons
(b) Address: 1318 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944, at 8:40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Burns, second & third degree entire body

Due to:

Other Conditions: Mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 14 1944 6:40 P.M.
(b) Where did injury occur? 1239 Haubert St.
(c) Did injury occur at home, on farm, industrial place, in public place? at Home While at work? No
(d) Means of injury: set herself afire

Signature H. L. Wallenmeyer M.D. Deputy Medical Examiner.
Date signed May 15 1944

G 17239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G 17237
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Preisler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-42

8. AGE: Years 2 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER — 12. Name George Preisler
13. Birthplace Md

MOTHER — 14. Maiden Name Elsie Black
15. Birthplace NC

16 (a) Informant Record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) May 17/44

(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Harry H. Fritze Asso.
(b) Address 1101 Edmondson Ave

19 (a) MAY 16 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1944 to May 14 1944 and that I last saw h[illegible] alive on May 14 1944

Immediate cause of death Burns
1° 2° 3°

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? (Fire) Accident
(b) Date of occurrence 5/11/44 at 5 P M
(c) Where did injury occur? 1926 Christian St Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burns. Clothes ignited, burning paper,

23. Signature [illegible] MD
Address Johns Hopkins Hospital Date signed 5/14/44

VS 150 For Dr. Whitridge Williams, by Howard J. Preisler M.D.

D 17238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓126

G 17238
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 N. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Maria Jerardi

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband late Philip Jerardi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17 1865

8. AGE: Years	Months	Days	If less than one day
79	3	23 24	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Jerardi
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Anna M. Hooper (Grand Daughter)
(b) Address 105 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (b)
(Signature of registrar) Registrar

MAY 16 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1944, to May 13 1944, and that I last saw her alive on May 11, 1944.

Immediate cause of death	Duration
Intestinal obstruction	1 ma.
Due to Dynamic Ileus	1 Month
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 9, 1944
Major findings of operation: Gall - Stones
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

27. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cronin M. D.
Address 5-14 W. Mulberry Lane Date signed 5/15/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G 17239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Blvd. & Dorsey St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK ANTHONY PRESKE

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	~~Married~~ Marr.

6 (b) Name of husband or wife: Estella Stroud
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1886

8. AGE: Years	Months	Days	If less than one day
57	9	6	hr. min.

9. Birthplace Evansville, Ind. (Town, county, and state)
10. Usual Occupation Retired- 18 yrs. ago
11. Industry or business -

FATHER
12. Name Frank Anthony Preske
13. Birthplace Riga, Westphalia

MOTHER
14. Maiden Name Barbara Wymziek
15. Birthplace ? Poland

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Natl
Location Frederick Ave., Balto. Md.

18 (a) Funeral director Easton Home
(b) Address Ellicott City, Md.

19 (a) MAY 16 1944 (Date received) (b) Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7, 1944, to May 13, 1944, and that I last saw him alive on May 13, 1944

Immediate cause of death: Ruptured appendix with peritonitis — Duration: 5/7/44

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Appendectomy 5/8/44

Major findings of operation: Ruptured appendix

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Albrecht M. D.
Address Baltimore, Md. Date signed 5/13/44

Va-14459

G 17240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G 17240 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1645 WILKINS AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 WILKINS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA DEGENER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife FREDERICK DEGENER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 7 1867

8. AGE: Years	Months	Days	If less than one day
76	9	9	hr. min.

9. Birthplace GERMANY. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name AUGUST BUCHEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant HENRY P DEGENER
(b) Address 1300 JAMES ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY-19-44 (month) (day) (year)
(c) Cemetery or crematory ST PAULS CEM
Location VIOLETSVILLE MD

18 (a) Funeral director Wm. Chas A. J. Rohde
(b) Address 3827 Edmondson Ave
(c) Washington Nikamus MD

MAY 16 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to May 16 1944 and that I last saw him alive on May 15 1944

Immediate cause of death: Arterio-Sclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Seagmeth M. D.
Address 1729 W Lombard Date signed 5/16/44

G 17241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G 17241 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Geisendaffer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George Geisendaffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27-1897

8. AGE: Years	Months	Days	If less than one day
46	5	18	hr. min.

9. Birthplace Balto MD
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business —

FATHER
12. Name John Steinfort
13. Birthplace Balto MD

MOTHER
14. Maiden Name Mollie Downs
15. Birthplace Balto MD

16 (a) Informant George Geisendaffer
(b) Address 706 No Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Balto MD

18 (a) Funeral director Bernard C Hess
(b) Address 121 E West St

19 (a) 1944 (Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15- 1944, at 1.10 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to Traumatic severance of right extremity;

Other Conditions Compound comminuted fracture left femur - avulsion of all tissues
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 23/1
(a) Date of injury 5-15- at 6.30 A M.
(b) Where did injury occur? Howard & Hamburg Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, run over by P.R.T. train

23. Signature Howard J. Cleveland M.D.
Medical Examiner.
Date signed 5/16/44

G 17242

BALTIMORE CITY HEALTH DEPARTMENT 17242 Registered No. 107

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 N. Calmer St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Jenifer

3 (b) If veteran, name war —

3 (c) Social Security Account No. None 97152 V

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/14/1944

8. AGE: Years	Months	Days	If less than one day
	2	1	hr. min.

9. Birthplace BALTO. MD. (Town, county and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace

MOTHER
14. Maiden Name Judith Jenifer
15. Birthplace BALTO. MD.

16 (a) Informant Mrs. DAVAGE
(b) Address 1624 ARGYLE Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location Md

18 (a) Funeral director Geo. A. Kelso
(b) Address 1303 Presstman St.

19 (a) MAY 16 1944 (Date received by registrar) (b) Registrar Houston for Williams, M.D.

VS 151

MEDICAL CERTIFICATION 35

20. DATE OF DEATH 5/15/1944, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner
Date signed 5/16/44 Homer J. Walters, M.D.

G 17243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17243 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Reynolds Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Reynolds Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaus Lewandowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-1029

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Apalonia Lewandowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Lewandowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Koslowski
15. Birthplace Poland

16 (a) Informant Mrs. Mary Rykowski
(b) Address 1413 Reynolds Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 E. Chester Street

19 (a) (Local registrar) (b) Registrar

MAY 16 1944 Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1944 to 5-13 1944.
and that I last saw him alive on 5-12 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to Arteriosclerosis — 6 mo.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. B. Gallod M.D.
Address 707 E. Fort Ave. Date signed 5-15-44

G 17244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17244
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S. Chester street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wladyslawa Sobotka

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Stanislaw Sobotka
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stanislaw Klasik
13. Birthplace Poland

MOTHER
14. Maiden Name ? Zadgurski
15. Birthplace Poland

16 (a) Informant Mr. Stanislaw Sobotka
(b) Address 303 S. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County
18 (a) Funeral director John M. Welsh
(b) Address 40[illegible] S. Chester St
19 (a) [illegible] Registrar

MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to May 15 1944 and that I last saw h[illegible] alive on May 15 1944

Immediate cause of death: Myocardial failure — Duration: 6 days
Due to: Acute Cholangitis
Due to:
Other Conditions: Arteriosclerosis, Diabetes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leo L. Kulacki M.D.
Address 126 S. Patterson Pk. Date signed May 16/44

G 17245 BALTIMORE CITY HEALTH DEPARTMENT G 17245
Registered No.

CERTIFICATE OF DEATH 1168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 649 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Larry J. McMickle

3 (b) If veteran, name war

3 (c) Social Security Account No. 53

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1941

8. AGE: Years	Months	Days	If less than one day
2	9	24	hr. min.

9. Birthplace La Grange Georgia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Oliver E. McMickle
13. Birthplace Columbia, Georgia

MOTHER
14. Maiden Name Jewell Bailey
15. Birthplace Riverview Ala.

16 (a) Informant Mrs. Jewell Pena
(b) Address 649 W. Fayette St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/18/44 (month) (day) (year)
(c) Cemetery or crematory Hillview Annex
Location La Grange Georgia

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Holmes St

19 (a) (Date received by Registrar) (b) Registrar

MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage, abdominal

Due to Blunt force

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-14-44 at M.
(b) Where did injury occur? street address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury struck with stick & fist

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 5-14-44

G 17246 — BALTIMORE CITY HEALTH DEPARTMENT — G 17246

CERTIFICATE OF DEATH 47D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore – 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Magnolia Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. ~~Jno~~ FREDERICH FRANCIS REITER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Olga N. Reiter

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1900

8. AGE: Years 43 | Months 05 | Days 18 | If less than one day: hr. min.

9. Birthplace: Hungary – Königshof (Town, county, and state)

10. Usual Occupation: Salesman + Clerk

11. Industry or business: Sheet metal supplies

FATHER
12. Name: Henry Reiter
13. Birthplace: Andreas, Hungary

MOTHER
14. Maiden Name: Catherine Miller
15. Birthplace: Königshof, (Now in Roumania) Hungary.

16 (a) Informant: Mrs Olga N Reiter
(b) Address: 5611 Magnolia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: A. A. Co. Md.

18 (a) Funeral director: C. Vernon Lawrence
(b) Address: 4611 Pk. Hgts.

19 (a) (b) (registrar) Huntington Williams, M.D.

MAY 16 1944
VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1944, at 12:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1944, to 5-14 1944, and that I last saw him alive on 5-14 1944.

Immediate cause of death: Hemopneumothorax right
Carcinoma left lung
Massive pleural effusion, right
Due to: Pulmonary congestion & edema in left lung
Due to:
Other Conditions: Possible tuberculosis pulmonary.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Le Roy W. Tilt M. D.
Address: University Hospital Date signed 5-14-44

G 17247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17247

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 E York St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2W
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 E York St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruby Agnes Crook

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1883

8. AGE: Years 60 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Middlesex Co Va (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name Albert Perry
13. Birthplace Va

MOTHER
14. Maiden Name Clara C Trader
15. Birthplace Va

16 (a) Informant John Crook
(b) Address 16 E York St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director William M. Marsch
(b) Address 715 Tyler St

19 (a) (b) (If by registrar) Registrar

MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944, at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939 to May 14 1944, and that I last saw her alive on May 12 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to: Hypertension Cardio vascular Disease

Due to:

Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Lenman M.D.

Address 212 Patterson Pk Ave Date signed 5/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

~~6~~ 17248 — Registered No. 6 17248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 E. Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 W
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2634 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Bayard Galey Black

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Black
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1874

8. AGE: Years: 69 | Months: 8 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: John N. Black
13. Birthplace: Maryland

MOTHER — 14. Maiden Name: Elizabeth Ewing
15. Birthplace: Maryland

16 (a) Informant: Nellie C. Black
(b) Address: 2634 N. Charles St. Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 17, 1944 (month) (day) (year)
(c) Cemetery or crematory: Charlestown
Location: Charlestown, Md

18 (a) Funeral director: Lee A. Patterson & Son
(b) Address: Perryville, Md

19 (Date received by registrar) MAY 16 1944 — Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1944 at 9:33 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9 1944 to 5/15 1944, and that I last saw him alive on 5/15 1944.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Cerebral-Vascular-Accident (Hemorrhage)	
Due to: Arteriosclerotic Heart Disease	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George W. Murgatroyd Jr. M. D.
Address: 332 E. University Pkwy Date signed: 5/16/44

17249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

GG 17249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. McKINLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 16 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

0956

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1944, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumonia, lobar

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed 4-30-44

G 17250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. G 17250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6704 Germanhill Road (If rural give location)
(e) Citizen of foreign country? Ma (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Korpi

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 056-18-2170

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hilya Korpi

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1896

8. AGE: Years 47 48 | Months 7 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace FINLAND (Town, county, and state)

10. Usual Occupation Ship-Fitter

11. Industry or business Bethlehem-Fairfield Ship Bldg. Co.

FATHER
12. Name Not Known
13. Birthplace Finland

MOTHER
14. Maiden Name Not Known
15. Birthplace Finland

16 (a) Informant Miss Mary Salo - Apt. 2-D
(b) Address 815 Park Ave. New York City.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 16 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) MAY 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944 at 2 04 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/20/44 at 6:54 A. M.
(b) Where did injury occur? 6704 Germanhill Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? —
(d) Means of injury asphyxiation due to hanging

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed 4-20-44

F 0958

G 17251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution Baltimore City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No. 298 Davis Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James (Bostrow) BALTIMORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored WHITE

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda Holston

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 4/8/1904

8. AGE: Years 40 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace: Richmond, Va.
(Town, county, and state)

10. Usual Occupation: Welder

11. Industry or business

FATHER
12. Name: James Richard Baltimore
13. Birthplace: Albemarle Co. Va.

MOTHER
14. Maiden Name: Minnie Anderson
15. Birthplace: Cumberland, Va.

16 (a) Informant: Minnie A. Baltimore
(b) Address: Hyattsville, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory: Ruppert Cem.
Location: Richmond, Va.

18 (a) Funeral director: John C. Miller, Inc.
(b) Address: 2435 E. Oliver St.

19 MAY 16 1944 (Date rec'd by registrar) (b) Christopher Williams, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1944, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Alcoholism.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Wallenmeyer M.D.
Medical Examiner.
Date signed May 2, 1944.

0957

G 17252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17252

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Wagners Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred C. Neuman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma (Sears)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1907

8. AGE: Years	Months	Days	If less than one day
37	3	11	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Roller
11. Industry or business Eastern Rolling Mills

FATHER
12. Name Christian Neuman
13. Birthplace Germany

MOTHER
14. Maiden Name Maxie Schmeistetter
15. Birthplace Germany

16 (a) Informant Mrs. Emma Neuman
(b) Address 8 Wagners Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May - 18 - 1944 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St.

18 (a) Funeral director John F. Connelly
(b) Address 448 Eastern Blvd

19 (a) MAY 16 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 9:30 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. E. Wallenmeyer M.D. (Medical Examiner.)
Date signed May 15 1944

(OVER)

G 17253 G 17253 G 17253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3313 Spaulding Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Spaulding Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reed W. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1895

8. AGE: Years 48 Months 5 Days 25 If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork + Seal Co

FATHER
12. Name Newton Miller
13. Birthplace Va

MOTHER
14. Maiden Name Julia Lambert
15. Birthplace Iowa

16 (a) Informant Mrs Helen Miller
(b) Address 3313 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V 7-18-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wendell E Humphreys
(b) Address 1501 N Broadway

19 (a) MAY 16 1944 (b) Registered by Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1944 at 4 30 P.M

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williams M.D. (Medical Examiner)
Date signed per Robert E. Proctor M.D. May 16 1944

G 17254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17254

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY WILSER

3 (b) If veteran, name war: Spanish-Amer.
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Emma Bernhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1874

8. AGE: Years	Months	Days	If less than one day
69	9	7/10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Master
11. Industry or business

FATHER
12. Name Theodore Wilser
13. Birthplace Germany

MOTHER
14. Maiden Name Wilheminia
15. Birthplace Germany

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May. 17. 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.,
Location Balto. Co. Md.

18 (a) Funeral director Henry Sander & Sons Inc
(b) Address North Ave - Broadway

(Date received) MAY 16 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1944, at 12:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 29, 1944 to May 14, 1944, and that I last saw him alive on May 14, 1944.

Immediate cause of death	Duration
Thrombosis, cerebral, lenticulos- acute artery, hemiplegia, left	Unk.
Due to Hypertensive cardiovascular disease; cerebral arteriosclerosi	Unk.
Due to ////// Cystitis, chronic.	Unk.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address U. S. Marine Hospital Date signed 5/15/44
Baltimore, Maryland.

17255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 17255
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5103 Cordelia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5103 Cordelia Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura Bright Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1873

8. AGE: Years	Months	Days	If less than one day
70	7	25	hr. min.

9. Birthplace Minneapolis, Minnesota (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Y. M. H. A.

FATHER
12. Name Francis Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Ada Sorier
15. Birthplace Germany.

16 (a) Informant Mrs. Laura B. Miller
(b) Address 5103 Cordelia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Bakersville, Md.

18 (a) Funeral director Loring & Byers.
(b) Address 3745 York Rd. Telephone

MAY 17 1944 (Date rec'd by registrar) Washington Millikan M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940 to May 15 1944, and that I last saw him alive on May 12 1944.

Immediate cause of death	Duration
Myocarditis.	1 yr.
Endocarditis.	
Due to Pneumonia, Lobar, Left Upper Lobe.	3 yrs.
Due to Hypertension.	
Other Conditions Arteriosclerosis.	2 months.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fred L. de Barbieri M. D.
Address 4723 Park Heights Ave. Date signed 5/16/44

~~8256~~ ~~54285~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

G 17256 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S C (b) County
(c) City or town Columbia (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Wateree Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert W. Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-44

8. AGE: Years | Months: 3 | Days: 14 | If less than one day: hr. min.

9. Birthplace: S Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Ralph Lewis
13. Birthplace S.C.

MOTHER: 14. Maiden Name Estelle Whitaker
15. Birthplace S C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19-44 (month) (day) (year)

(c) Cemetery or crematory
Location South Carolina

18 (a) Funeral director Ellsworth Arnacost
(b) Address 3911 Liberty Heights Ave

19 MAY 17 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944, to May 16 1944, and that I last saw h.IM alive on May 16 1944

Immediate cause of death: Congenital Hydrocephalus — Duration: 3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation S 11 '43

Major findings of operation: Obstruction of Sylvian Aqueduct

of autopsy: Same

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1 H Date signed 5/17

17257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 17257

Every item of information should be carefully supplied. The ... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 Mc Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Logan

3 (b) If veteran, name war	3 (c) Social Security Account No.
none.	705-05-3560.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife Bessie A. Logan.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 17-1881.

8. AGE: Years	Months	Days	If less than one day
62	8	28	hr. min.

9. Birthplace Granit - Md. (Town, county and state)
10. Usual Occupation Machinist
11. Industry or business B. & O. R.R. Co.

FATHER
12. Name Andrew Logan.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Ida Isaac.
15. Birthplace Md.

16 (a) Informant Mrs. Bessie A. Logan.
(b) Address 2529 Mc Henry St.

17 (a) Burial. (b) Date thereof May 18-44. (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

MAY 17 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944, to 5-15 1944, and that I last saw h[illegible] alive on 5-15 1944.

Immediate cause of death: Respiratory failure — Duration
Due to Hypertensive Cardio-Vascular Disease
Due to Cerebro-Vascular accident
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. U. Latimer Jr. M.D. M. D.
Address Univ. Hosp. Date signed 5-15-44

M. D. S. 1944

17258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

17258

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Greyson Ave Ward)

Registered No. 7830

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs. ....mos. ....ds. How long in U. S. If of foreign birth? ....yrs. ....mos. ....ds.

2. FULL NAME Julia Catharine Sullivan

(a) Residence: No. 413 Greyson Ave Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Widow

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Sullivan

6. DATE OF BIRTH (month, day, year) July 6 - 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	10	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Accomac Co. Va
(State or country)

FATHER

13. NAME Joshua T. Reed

14. BIRTHPLACE (city or town) Accomac Co Va
(State or country)

MOTHER

15. MAIDEN NAME Charity Hall

16. BIRTHPLACE (city or town) Accomac Co Va
(State or country)

17. INFORMANT Bella Taylor Reynolds

(Address) Chincoteague Va.

18. BURIAL, CREMATION, OR REMOVAL

Place Accomac Va. Date May 19 1944

19. UNDERTAKER F. D. Mapp & Son

(Address) Bloxom Va.

FILED MAY 17 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 16 1944

22. I HEREBY CERTIFY, That I attended deceased from May 11 1944, to May 16 1944

I last saw h.im alive on May 16 1944. Death is said to have occurred on the date stated above, at 8 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
"Cerebral arteriosclerosis"	May 11-44
Arteriosclerosis —	Unknown
& Myocardial degeneration. —	

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury ....19....

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? — If so, specify —

(Signed) M Bernard Reed M. D.

(Address) 2200 Garrison Blvd

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

v. 9. 3

17259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 17259

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Benjamin Fillo Parkway
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Benjamin Fillo Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Charlotte Moore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. ~~Sex~~ Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/3/1875

8. AGE: Years 70 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER — 12. Name Gustavus J. Moore
13. Birthplace Georgia

MOTHER — 14. Maiden Name Mary S. Hasson
15. Birthplace Md.

16 (a) Informant Mrs. Adele Moore
(b) Address 711 Benjamin Fillo Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore.
Location Baltimore, Md.

18 (a) Funeral director E. D. Wippert & Son
(b) Address 300 Eutaw Place.

MAY 17 1944 (Date filed by Registrar) Huntington Williams, M.D. Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to May 13, 1944, and that I last saw h[illegible] alive on May 13 1944.

Immediate cause of death Heart failure — Duration About three (3) years

Due to Chronic Cardiac Disease — Duration —

Due to Hypertension — Duration —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wm Greenfield M. D.
Address 821 Eutaw Pl. Date signed 5/16/44

17260

A-37754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G 17260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) ~~Baltimore~~ City, ~~Maryland~~

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs. 15 Min

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 N. Howard St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2-1944

8. AGE: Years	Months	Days	If less than one day
			9 hr. 15 min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Patterson
13. Birthplace ?

MOTHER
14. Maiden Name Charlotte Bond
15. Birthplace Md

16 (a) Informant Baltimore City Hospitals
(b) Address Records 5-15-44

17 (a) Cremation (b) Date thereof 5-4-44 9 am
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director

(b) Address

19 MAY 17 1944 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1944, to 5-3 1944, and that I last saw her alive on 5-3 1944

Immediate cause of death Intracranial hemorrhage — Duration 9hr. 15min.

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. E. Russell M.D.

Address Balto. City Hosp. Date signed 5-5-44

G 17261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17261

TN. 87913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 E. Eager St, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Timothy L. Dailey (Daily)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3rd, 1903

8. AGE: Years 41 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Timothy Dailey (D Daily
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Lanahan (D
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St

19 (a) (b) Huntington Williams, M.D. Registrar

MAY 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16 1944, at 9.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1944, to 5-16 1944, and that I last saw h[illegible] alive on 5-16 1944.

Immediate cause of death: Bilateral Embolism of Pulmonary Arteries. — Duration: 1 day

Due to

Due to

Other Conditions: Cirrhosis of Liver — Duration: 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattoni M.D.
Address B.C.H. Date signed 5/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 17262

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Ridgewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Penn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Joseph Hertzbach
13. Birthplace: Russia

MOTHER
14. Maiden Name: Baila ?
15. Birthplace: Russia

16 (a) Informant: Mr Solomon Penn
(b) Address: 2914 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

MAY 17 1944 (Date received by registrar) Huntington Williams (Registrar)

VS.180

MEDICAL CERTIFICATION

8.30

20. DATE OF DEATH: May 16, 1944, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 41 to May 16 1944, and that I last saw her alive on May 16 1944.

Immediate cause of death: Carcinoma Gall Bladder — Duration: 3 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: April 1941

Major findings of operation: Malignancy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M J Braylin

Address: 7040 Eastern Date signed: 5/17/44 M.D.

G 17263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17263 Registered No. 1860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Maryland Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Crownsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams Saylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1909

8. AGE: Years	Months	Days	If less than one day
35	2	8	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Carpenters.
11. Industry or business

FATHER
12. Name Frank Saylor
13. Birthplace

MOTHER
14. Maiden Name Flossie Brady
15. Birthplace Pennsylvania

16 (a) Informant Mrs. M. K. Johnson
(b) Address 64 Old Annapolis Rd.

17 (a) Removal (b) Date thereof 5/17/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lock Haven Pa.
Location

18 (a) Funeral director Wm J Tickner & Sons
(b) Address N. Y. Ave.

19 (a) MAY 17 1944 (Date rec'd by registrar) Hamilton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at 11:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull, multiple fractures of ribs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 16, 1944 11:15 A.M.
(b) Where did injury occur? Maryland Hwy Route Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell 35' onto ship

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 16, 1944

VS 151

Correct age in carefully interpreting. Physicians, please write clearly and legibly.

17264 ✓ G 17264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Cutland St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 S. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baworski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1944

8. AGE: Years | Months | Days 1 | If less than one day: 40 hrs. 16 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name John Ignatius Baworski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Radomski
15. Birthplace Poland

16 (a) Informant Mother
(b) Address 715 S. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester Street

19 (a) MAY 17 1944 Registrar's Office Baltimore, Md. (b) Undertaker's License No. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944, at 1:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944 to May 14 1944 and that I last saw h[illegible] alive on May 4 1944

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: no pathology found

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.
Address Sinai Hosp. Date signed 5/15/44

VS 3

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G 17265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 17265 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Enson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Enson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis M. Patton

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Louise Patton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Bolivar, Tenn (Town, county, and state)
10. Usual Occupation Molder
11. Industry or business

FATHER
12. Name Willis Patton
13. Birthplace Tenn

MOTHER
14. Maiden Name Amy Hall
15. Birthplace Tenn,

16 (a) Informant Louise Patton
(b) Address 1923 Kelly ave. nt. Washington md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Belmont ave

19 (a) (Date received by registrar) MAY 17 1944 (b) Baltimore, Md. Registrar

VS 150

5-14-44 **MEDICAL CERTIFICATION** 11:20 PM

20. DATE OF DEATH 5-14- 1944, at 1130 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8- 1944, to 5-14- 1944, and that I last saw him alive on 5-13- 1944.

Immediate cause of death Lobar Pneumonia — Duration 8 dys

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Cargill M. D.
Address 611 - N. Caroline Date signed 5-16-44

CARGILL

G 17266 ✓ G 17266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 N. Ann St
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 N. Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rappaport

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Fabish Rappaport

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Hyde Rappa
13. Birthplace Russia

MOTHER
14. Maiden Name Rydie —
15. Birthplace Russia

16 (a) Informant Samuel Rappaport
(b) Address 237 N. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAY 17 1944

Lippincott Robert Lee Graham M.D. May 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to March 7 1944 and that I last saw h[illegible] alive on 3/7 1944.

Immediate cause of death: Hemorrhage into Cerebrum 1 day — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon
Address 129 S. Bway Date signed 5/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17267 ✓ G 17267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 RESERVOIR ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 RESERVOIR ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MALIE BECK

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife SAMUEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1851

8. AGE: Years 93 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name SAMUEL SANUEL KRIEGER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ESTHER
15. Birthplace RUSSIA

16 (a) Informant MR. JOSEPH BECK
(b) Address 804 RESERVOIR ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)
(c) Cemetery or crematory BALTO. HEBREW
Location BELAIR RD

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St

19 (a) MAY 17 1944 Registered by registrar [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16-44 19 35 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1924 to 5/16 1944 and that I last saw h[illegible] alive on 5/16 1944

Immediate cause of death Heart failure — Duration 20 yrs

Due to General Debility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Goldberg D

Address 2452 Eutaw Pl Date signed 5/17/44

G 17268 ✓ G 17268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 18 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 1746 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1746 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM J. SCOTT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1871

8. AGE: Years 73 | Months 2 | Days 13 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Own Business

MOTHER / FATHER
12. Name William J. Scott
13. Birthplace --
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mr. Kenneth W. Scott
(b) Address 2023 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 18 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1944, at 5:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1944 to May 14, 1944, and that I last saw h[illegible] alive on May 14, 1944.

Immediate cause of death: Carcinoma Prostate gland — Duration: 1 year
Due to:
Due to:
Other Conditions metastases to lung & pleurisy — Duration: 1 week
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M.D.
Address 1 and 2 S Charles St Date signed 5/16/44

G 17269 ✓ G 17269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4803 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4803 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES LeROY SUMMERS, SR.

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Gladys P. Summers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/1/1893
8. AGE: Years 51 | Months 4 | Days 15 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Coal
11. Industry or business Williams Coal Co.

FATHER
12. Name Charles B. Summers
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Minnie Merz
15. Birthplace Balto., Md.

16 (a) Informant Mr. Lindnee T. Summers
(b) Address 5316 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 17 1944 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1944, at 5:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4/43 to 5/16/44 and that I last saw h alive on 5/16/44

Immediate cause of death Coronary occlusion — 1 — 1/22

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harper
Address 5201 Gwynn Oak Date signed 5/17/44 D.

17270

AB-87783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17270

152

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25- 1913

8. AGE: Years 30 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Ellis (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Emma Horn (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Wilson N. C.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Signature of registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at 12.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 1944 to 5/16 1944 and that I last saw her alive on 5/16 1944.

Immediate cause of death: Prob. acute lupus erythematosis disseminata — Duration: 4 wks.
Due to
Due to
Other Conditions: Cardiac decompensation & Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Seigman M. D.
Address BCH Date signed 5/16

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17271 — Registered No.

T.N. G 17271 87280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cheeves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1914

8. AGE: Years	Months	Days	If less than one day
30	3	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Cheeves
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace Del.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19- (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill - A.A. Co. Md

18 (a) Funeral director Mrs. Kristin R. Williams
(b) Address 322 N. Belnord Ave.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 0^20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1944 to 5-15 1944 and that I last saw h[im] alive on 5-15 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Martin M.D.
Address B.C.H. Date signed 5/15/44

G 17272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 17272 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Buntin Buntin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1 1891

8. AGE: Years 52 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Accomac-Co—Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Buntin Buntin
13. Birthplace Va.

MOTHER
14. Maiden Name Caroline Johnson
15. Birthplace Va

16 (a) Informant Mrs. Lillian Hackenbutton
(b) Address 940 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Alexander St

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 17 1944 Registrar Millicent M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 14 1944 and that I last saw him alive on May 12 1944.

Immediate cause of death: Apoplexy — Duration

Due to Hypertension

Due to Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2039 W Baltimore Date signed 5-16-44 M. D.

G 17273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G 17273 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3464 Cardenas Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Nannie Clift (Nannie Gresham Clift)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	F	W	MARRIED Single

6 (b) Name of husband or wife George F. Clift
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	1	5		

9. Birthplace Whitestone Lancaster Co., Virginia (Town, county, and state)
10. Usual Occupation practical Nurse
11. Industry or business

FATHER
12. Name James R. Gresham
13. Birthplace Va.

MOTHER
14. Maiden Name Louemma --
15. Birthplace --

16 (a) Informant Mrs. Gresham C. Downs
(b) Address 3121 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 17 1944 (b) [illegible] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 5:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1944 to May 16 1944, and that I last saw her alive on May 15 1944.

Immediate cause of death	Duration
Respiratory failure	18 hrs
Due to Continued elevation of temperature	3 mo
Due to Cause Unknown	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes - Enlarged iliac nodes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Felix Rutledge M. D.
Address Womens Hospital 5-16-44

17274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 17274

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Braddish Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Braddish Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Rice

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or ~~wife~~ John Wm. Rice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1892

8. AGE: Years 51 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name John Kiernan
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Smith
15. Birthplace Md.

16 (a) Informant John Wm. Rice
(b) Address 1712 Braddish Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18,1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director St. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) MAY 17 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1944 at 10.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 5/15 1944 and that I last saw h.e. alive on 5/15 1944

Immediate cause of death: Hemiplegia — Duration: 5 days
Due to: Arteriosclerosis — 4 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 20204 Clarke Date signed 5/16/44

G 17275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

G 17275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1146 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norreet Jolly

3 (b) If veteran, name war —

3 (c) Social Security Account No. 251-05-7300

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie Jolly

6 (c) If alive, give age — yrs.

7. Birth date of deceased (mo., day, yr.): 1895 ~~1896~~

8. AGE: Years	Months	Days	If less than one day
49 6			hr. min.

9. Birthplace: Gaffney S.C. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Monroe Jolly
13. Birthplace: Gaffney S.C.

MOTHER
14. Maiden Name:
15. Birthplace: Gaffney S.C.

16 (a) Informant: Hattie Jolly
(b) Address: 1005 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 18 1944 (month) (day) (year)
(c) Cemetery or crematory: Concord Cemetery
Location: Gaffney S.C.

18 (a) Funeral director: Robert E. Williams
(b) Address: 1515 McElderry St.

19 (a) (Date received by Registrar) MAY 17 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1944, at 8 15 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of left tibia & fibula

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: May 6 '44 12/5 10:30 P. M.
(b) Where did injury occur? North ave. & Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury: Pedestrian struck by auto

23. Signature: H. L. Wollenmeber M.D. Medical Examiner.
Date signed 5-13-44

(OVER)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

320571 G 17276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G 17276 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 Colvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Obie McRey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-30 1930

8. AGE: Years	Months	Days	If less than one day
13	8	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John H McRey
13. Birthplace S.C.

MOTHER
14. Maiden Name Annie Aulston
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b) Huntington Williamsport Md

MAY 17 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 2:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944 to May 14 1944 and that I last saw h alive on May 14 1944

Immediate cause of death	Duration
Tuberculous Meningitis	11 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M.D.
Address Johns Hopkins Hosp. Date signed 5/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V166

C 17277 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 688 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 21 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Elevatorman

11. Industry or business Sol Bar

FATHER 12. Name Sam Boston

13. Birthplace Md.

MOTHER 14. Maiden Name Ida Clarkson

15. Birthplace Penn.

16 (a) Informant Mrs. Elizabeth Oliver

(b) Address 688 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

MAY 17 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1944, at 10 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-13-44 M.

(b) Where did injury occur? 697 W. Mulberry St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?

(d) Means of injury Revolver

23. Signature H. L. Wallenmeier M.D. (Medical Examiner.)

Date signed 5-14-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 1728. BALTIMORE CITY HEALTH DEPARTMENT G 17278 Registered No.

CERTIFICATE OF DEATH 944a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-13
(e) Length of stay in Baltimore (yrs., mos., or days) 1-0-13

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 148 Baldwin Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ida Hare

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1859

8. AGE: Years 84 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Norfolk, Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Ray Roberts
13. Birthplace Gloucester, Virginia

MOTHER
14. Maiden Name Jane Cecilia Nagy
15. Birthplace Norfolk, Virginia

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory Norfolk Va
Location Norfolk Va

18 (a) Funeral director J. J. Lohey & Sons
(b) Address 1318 Light St.

19 MAY 17 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944, at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1943, to May 17 1944, and that I last saw h[illegible] alive on May 17 1944.

	Duration
Immediate cause of death: Myocardial infarct	2 wks
Due to: General arteriosclerosis - marked	?
Due to:	
Other Conditions: Senile Psychosis Paranoid phrenic type (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damon P. Nagle M. D.
Address 33 W. Lanvale St. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 17279. G 17279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Eutaw Place
(c) Hospital or institution: none 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Reese Sprigg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: Walter P. Sprigg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. , 1884

8. AGE: Years 59 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Daniel Reese
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant George H. Hillary
(b) Address 2808 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) Hamilton Williams, M.D. Registrar

MAY 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to May 15 1944, and that I last saw him alive on 5-15- 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	3 hrs
Due to Arteriosclerosis	3 yrs
Due to Chron. Renal disease	7 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1901 Eutaw Place Date signed 5/16/44 M. D.

G 17280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 17280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 E. Fort ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 E. Fort ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Walker Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Veronica Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1890

8. AGE: Years 53 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B. & O. R.R.

FATHER
12. Name Stephen F. Walker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna M. Piorncek
15. Birthplace Balto, Md

16 (a) Informant Mrs. Anna Kirschmann
(b) Address 1334 E. Fort ave

17 (a) [illegible] Burial (b) Date thereof May 18, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) MAY 17 1944 [illegible] Washington Blvd

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944 to 5-15 1944, and that I last saw [illegible] alive on 5-12 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	1 Day
Due to: Arteriosclerosis	6 mo.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Hollod M. D.
Address 707 E. Fort Ave. Date signed 5-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

106a

Registered No. G 17281

5217 Harford Rd.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5713 Hartford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5713 Hartford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Ann Ehrhardt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 30, 1861

8. AGE: Years 82 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William White
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Barbour
15. Birthplace ?

16 (a) Informant Mr. Wm Hor Ehrhardt
(b) Address 5713 Hartford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Catonsville

18 (a) Funeral director Leonard Keech
(b) Address 5305 Harford Rd

19 (a) MAY 17 1944 Harrington Williams Mort

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to May 16 1944, and that I last saw h alive on 19

	Duration
Immediate cause of death: Acute Cardiac Dilatation.	
Due to: Hypertension - Arteriosclerosis.	
Due to:	
Other Conditions: Acute Bronchitis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Hor Ehrhardt

Address 5217 Harford Rd. Date signed 5/16/1944

17252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G 17252

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Caroline st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife John H. Spencer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1901

8. AGE: Years	Months	Days	If less than one day
42	11	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Mack Veney
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant John H. Spencer
(b) Address 1925 E. Preston st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilcox
(b) Address 1000 Brantly Lane

MAY 17 1944 (Date received by Registrar) Hampton Williams, M.D.

VS 160

5-14-44 **MEDICAL CERTIFICATION** 1145 P.M.

20. DATE OF DEATH 5.15 1944 at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1943 to 5/15 1944
and that I last saw h[illegible] alive on 5-14 1944

Immediate cause of death Carcinomatosis — Duration

Due to carcinoma of left breast — 1 yr

Due to

Other Conditions

(Include pregnancy within three months of death)
Date of operation 6/43
Major findings of operation: Carcinoma of breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne
Address 15 W. C. Madison St Date signed 5/16

Rayner Browne

HUEBSCHMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G 17283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Conkling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas M. Huebschmann

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: ?

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1877

8. AGE: Years 66 | Months 9 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business Self Baltimore Laundry

FATHER
12. Name George Huebschmann
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Beckman
15. Birthplace Baltimore Md

16 (a) Informant Catherine M. Huebschmann
(b) Address 8 S. Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Ann.
Location Trappe Road

18 (a) Funeral director Wenzel Weigand
(b) Address 312 [illegible]

19 (a) MAY 17 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 9:10 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of stomach

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed May 16, 1944

G 17284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 a

G 17284 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Hampton Court apts.
(b) Street address 309 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Dolphin St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Hanson Rossetter Fowler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frederick Fowler
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 11 1852
8. AGE: Years 92 Months 32 Days 6 If less than one day hr. min.
9. Birthplace San Francisco Cal (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward J. Rossetter
13. Birthplace Bridgeport Conn.

MOTHER
14. Maiden Name Mary Martha Hanson
15. Birthplace Baltimore Md

16 (a) Informant Miss Laura Fowler
(b) Address 309 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry McSherry's Sons
(b) Address 847 Carlton - Orchard Sts

19 (a) MAY 17 1944 Registrar
Registration District No. Baltimore, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944 at 9 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944, to May 17 1944, and that I last saw her alive on May 16 1944.

Immediate cause of death: arteriosclerosis — Uraemia — Duration: 20 yrs. — 7 days

Due to: chronic nephritis — 2

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charlotte McCarthy M. D.
Address 101 Read St. Baltimore Date signed May 17 44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

XL - 83568

G 17255 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 - 23

(e) Length of stay in Baltimore (yrs., mos., or days): 26 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 3453 Juneway, [illegible] (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3 (a) FULL NAME: Rosa Ferreri

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 5, 1900

8. AGE: Years: 44 Months: 2 Days: 10 If less than one day: hr. min.

9. Birthplace: Colorado (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER — 12. Name: Joseph Garbo

FATHER — 13. Birthplace: Colorado

MOTHER — 14. Maiden Name: Rosa ?

MOTHER — 15. Birthplace: Colorado

16 (a) Informant: B. C. H. Records

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 17-44 (month) (day) (year)

(c) Cemetery or crematory: Cathedral

Location:

18 (a) Funeral director: Frank V. Pipitone

(b) Address: 218 E. Balto St

19 (a) (b) Date rec'd by registrar: MAY 17 1944 Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1944, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1944, to 5/15 1944, and that I last saw h[illegible] alive on 5/15 1944.

Immediate cause of death: Pulmonary TBC c recent miliary spread — Duration:

Due to:

Due to:

Other Conditions: Genito-urinal fistulae c TBC enteritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Ad Nauseum

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: E. L. Seigman M.D.

Address: BCH Date signed: 5-16

17286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125 B

Registered No. 17286

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/11/44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7277 Holabird Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORMAN JOHN HEINLEIN

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret Bresnick
6 (c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): 8/9/1922

8. AGE: Years	Months	Days	If less than one day
21	9	7	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Fireman 2/c
11. Industry or business: U. S. Naval Reserve

FATHER
12. Name: William Heinlein
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth Koch
15. Birthplace: Baltimore, Md.

16 (a) Informant: Records, U.S.Marine Hosp.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Extended

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

(b) Date received: MAY 18 1944 Registrar: Huntington Williams, M.D.

VS 250

MEDICAL CERTIFICATION

As

20. DATE OF DEATH May 16, 1944, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11, 1944 to May 16, 1944 and that I last saw him alive on May 16, 1944

Immediate cause of death: 1. Acute gastro enteritis, type undetermined; 2. Acute toxic nephritis & hepatitis with areas of necrosis (due to #1); 3. Terminal bronchial pneumonia (due to #1).

Duration: Unk. / Unk. / Sev. days

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. E. Bellamy, M. D.
Address Baltimore, Md. Date signed 5/16/44

USNR

JAKIMOVITZ

17287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. 17287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 Catalpa Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Jakimovitz

3 (b) If veteran, name war: N

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: Paul Jakimovitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/22/1880

8. AGE: Years	Months	Days	If less than one day
64 63	1	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

MOTHER / FATHER
12. Name Henry Hagemeyer
13. Birthplace Germany
14. Maiden Name Amelia (Unknown)
15. Birthplace Va.

16 (a) Informant Paul E. Jakimovitz
(b) Address 4702 Catalpha Rd.

17 (a) Burial (b) Date thereof 5/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Russian Orthodox
Location Washington Blvd

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAY 18 1944 Washington Williams, M.D.
(Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16 1944, at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944, to May 16 1944, and that I last saw her alive on May 16 1944

Immediate cause of death Renal Obstruction + Uremia — Duration

Due to Carcinoma cervix uteri

Due to

Other Conditions Thrombophlebitis Left leg. Recto-vaginal Fistula

(Include pregnancy within 3 months of death)

Date of operation Trans 2/1942 at Mercy Hosp

Major findings of operation: Irradiation

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Henry Hatch M. D.

Address C.H.N. Date signed 5-17-44

17288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 17288
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Miles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gazely

3 (b) If veteran, name war: 10

3 (c) Social Security Account No. 212-10-3018

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Nora E. Gazely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year): June 17th 1891

8. AGE: Years: 52 | Months: 10 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Grasselli Chemical Co

FATHER
12. Name: Gazely
13. Birthplace: Greece

MOTHER
14. Maiden Name: Mary A. Strong
15. Birthplace: Pa.

16 (a) Informant: Mrs Nora E. Gazely
(b) Address: 2909 Miles ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/20/44 (month) (day) (year)
(c) Cemetery or crematory: Balto
Location: " Md

18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 St. Paul St

19 MAY 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th 1944 at 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to May 16 1944, and that I last saw him alive on May 16 1944

Immediate cause of death	Duration
Obstruction of Heart	1 day
Chronic Lung	
Due to Myo-Cardite	6 mo.
Interstitial	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2824 St. Paul St Date signed May 17-44

VE 150

17289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17289 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 N. Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 N. Washington Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aida Paulene Pegg.,

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Frank Pegg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 29, 1883

8. AGE: Years 60 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation: High's Ice Cream Store,
11. Industry or business: Lakewood & McElderry Sts.

FATHER
12. Name: William P
13. Birthplace:

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Frank W. Pegg (Son)
(b) Address: 702 N. Port Street.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18, 1944. (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave.,

18 (a) Funeral director: Charles E. Schimunek.
(b) Address: 2601 E. Madison Street.,

19 (a) Date received: MAY 18 1944 (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1944, at 6:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8-1944 to 5-15-1944, and that I last saw her alive on 5-15-1944

Immediate cause of death	Duration
Acute myocardial failure	2 days
Due to Chronic myocarditis (Cause unknown)	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo. B. Lytle M. D.
Address 2802 Harford Rd Date signed 5-16-44

G 17290 ✓ G 17290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: Mt Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 2504 Mosher St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA WANTZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife 9 F Wantz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1. 1866

8. AGE: Years 77 | Months 8 | Days 17 16 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name DANIAL MEUSEL

13. Birthplace GERMANY.

MOTHER 14. Maiden Name NOT KNOWN

15. Birthplace GERMANY

16 (a) Informant MRS EDWIN WANTZ

(b) Address 2504 MOSHER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-19-44 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTO MD

18 (a) Funeral director Mrs Chas H Sehde

(b) Address 2327 Edmondson Ave

19 (a) MAY 18 1944 (Date received by Dist. Reg.) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944 to May 17 1944 and that I last saw her alive on May 17 1944

Immediate cause of death Carotiac decompensation — Duration

Due to

Due to

Other Conditions Bos Ca of ovary Intestinal obstruction Acute

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

Signature David J Taylor M.D.

Address West Balto Gen Hosp Date signed 5/17/44

7297 Dr. Campbell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9/a

✓ G 17291 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Madison Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia L. Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1903

8. AGE: Years	Months	Days	If less than one day
31	1	27	hr. min.

9. Birthplace Franklin, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Willis Jenkins
13. Birthplace Franklin, Va.

MOTHER
14. Maiden Name Elizabeth Berry
15. Birthplace Franklin Va

16 (a) Informant Samuel Cole
(b) Address 1615 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lavinia A. Stallard
(b) Address 1631 Druid Hill Ave
(c) [illegible] (Licensed undertaker) Huntington Williams, M.D.

MAY 18 1944 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14- 1944 at 8:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to May 1944, and that I last saw her alive on May 12, 1944

Immediate cause of death Subacute bacterial endocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell, M. D.
Address 718 Dolphin St. Date signed 5-15-44

17292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 Registered No. 17292

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2422 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE LANG

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Christian Lang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1857

8. AGE: Years	Months	Days	If less than one day
87	1	4	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Maurer
13. Birthplace Germany

MOTHER
14. Maiden Name Otilla Oster
15. Birthplace Germany

16 (a) Informant Mr. Wm. J. Lang
(b) Address 2422 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received MAY 18 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1944, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 19__ to MAY 16 1944, and that I last saw her alive on MAY 14 1944.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	21 DAYS
Due to HYPERTENSION	YEARS
Due to CHRONIC INTERSTITIAL NEPHRITIS	2 or 3 YEARS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Hoffman, M. D.
M. D.
Address 8 East Read St. Date signed 5/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 17293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3123 Abell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE E. HERSH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Salina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 2, 1864

8. AGE: Years: about 79 | Months: 10 | Days: 15 | If less than one day: hr. min.

9. Birthplace: York Co., Pa. (Town, county, and state)

10. Usual Occupation: Lawyer

11. Industry or business: Self

FATHER
12. Name: George Hersh
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Henrietta Cox
15. Birthplace: Pa.

16 (a) Informant: Mrs. Harriette Siemers
(b) Address: 3123 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory
Location: Taneytown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (Date received by registrar) MAY 18 1944 (b) Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944, at 1:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1944 to May 17 1944, and that I last saw h[illegible] alive on May 16 1944.

Immediate cause of death	Duration
Hypostasis of heart	12 hrs
Due to Coma Uremia	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2424 St. Paul St Date signed May 18-44

2 Copies. 7294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 17294

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Cleveland St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Cleveland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ellen Lutz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Peter A. Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1872

8. AGE: Years	Months	Days	If less than one day
71	4	20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business Own home.

FATHER
12. Name Peter Salzig
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Meis
15. Birthplace Germany

16 (a) Informant Peter A. Lutz
(b) Address 1207 Cleveland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Harry F. Wilkes
(b) Address 4101 Edmondson Ave.

MAY 18 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1944, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944 to May 15 1944 and that I last saw her alive on May 14 1944.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Arteriosclerotic Cardiovascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel J. Wolf M. D.
Address 1331 E. Madison Date signed

17295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G 17295 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Annah Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Wuntz.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife (Wife)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1881

8. AGE: Years	Months	Days	If less than one day
62	10	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Piano Tuner.

11. Industry or business

FATHER
12. Name Herman Wuntz
13. Birthplace Germany

MOTHER
14. Maiden Name Hensler (Johana)
15. Birthplace Germany

16 (a) Informant Herman Wuntz
(b) Address 3041 Annah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Henry A. Witzke
(b) Address 410 Edmondson Ave

MAY 18 1944

(c) Filed by Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to May 16 1944, and that I last saw h/m alive on May 16 1944.

Immediate cause of death	Duration
Pulmonary Congestion + Acute Bacterial Endocarditis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Endocarditis - Pulmonary Congestion Patient expired on table

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Gutelman M.D.

Address University Hospital Date signed 5/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 89015 G 17296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17296 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29Mins.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 Mins.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 897 S. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BabyGirl Pierce HELEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1944

8. AGE: Years | Months | Days | If less than one day: hr. 29 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Pierce
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Mack
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location BALTIMORE, Md.

18 (a) Funeral director George A. Weber
(b) Address 704 S. Amity street

19 MAY 18 1944 (Registrar's signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15- 1944 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15- 1944 to 5-15- 1944 and that I last saw her alive on 5-15- 1944

Immediate cause of death	Duration
ANOXIA	
Due to Congenital Atelectasis	
Due to Prematurity	
Other Conditions Placenta previa maternal (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Russell M.D. M. D.
Balto. City Hospitals Date signed 5-15-44

G 17297 | BALTIMORE CITY HEALTH DEPARTMENT | G 17297

CERTIFICATE OF DEATH

938 | Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Lawson

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1884

8. AGE: Years	Months	Days	If less than one day
59	11	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation House Keeper
11. Industry or business home

FATHER
12. Name David H. Lawson
13. Birthplace Maryland

MOTHER
14. Maiden Name Laronda Redeny
15. Birthplace Pennsylvania

16 (a) Informant Hilda Yarbe
(b) Address Garrison, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21/44 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Baltimore
18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown Md.

19 (a) (Date received by registrar) (b)

MAY 18 1944

Huntington Hollowell, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/44 19 , at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14/1944 to 5/17 1944 and that I last saw her alive on 5/17 19 44

Immediate cause of death: Respiratory Failure — Duration

Due to Hypertensive Cardio Vascular Disease

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clyde Roberts, Jr. M.D. M. D.
Address University Hosp Date signed 5/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B 17298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G 17298

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid Hill Ave.
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 N. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Charles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Aa	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-28

8. AGE: Years	Months	Days	If less than one day
16 17	0 4	0 2	hr. min.

9. Birthplace Kershaw Co. S. C.
(Town, county, and state)
10. Usual Occupation Boy
11. Industry or business

FATHER
12. Name Joseph Charles
13. Birthplace S. C.

MOTHER
14. Maiden Name Minnie Corbette
15. Birthplace S. C.

16 (a) Informant Mrs. M. Corbette
(b) Address 1146 N. Calhoun St

17 (a) Burial (b) Date thereof 5/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Camden
Location South Carolina

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Presstman St Walbrook

19 (a) (b) Huntington Woolfolk Registrar
(Date rec'd by registrar)

MAY 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/1944, at 4 25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/1944 to 5/17/1944, and that I last saw him alive on 5/16/1944

Immediate cause of death	Duration
Hemorrhage Peritonitis	
Due to Ruptured Appendix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/1/44
Major findings of operation: Ruptured Gangrenous Appendix
of autopsy: Hemorrhage Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Bernard Harris
Address Provident Hospital Date signed 5/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 17259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 2433 Madison Ave
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Walston

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15-1885

8. AGE: Years 58 | Months 8 9 | Days 2 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Lamb Walston (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty Kahler (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery or crematory Cylvertes
Location Md.

18 (a) Funeral director Wes. G. Kelson
(b) Address 1303 Preston

19 (a) (Date rec'd by registrar) (b) Registrar
MAY 18 1944 Huntington Milwaukie, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17-1 19 44, at 2.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1944 to 5-17 1944, and that I last saw alive on 5-17 1944

Immediate cause of death: Carcinoma of Lung — Duration: 7

Due to: c Metastasis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Hall
Address Balt City Hosp Date signed 5-18-44

G 17300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17300 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1560 Richland Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1560 Richland Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~: Frank Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1861

8. AGE: Years 83 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Hall
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Hall
15. Birthplace Md

16 (a) Informant Elizabeth Conyer
(b) Address 1560 Richland Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Calvert Co. Md

18 (a) Funeral director Wm. D. Nelson
(b) Address 1303 Pennsylvania Av

19 (a) (Date received by registrar) MAY 18 1944 (Signature of registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19xx, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 19xx to May 16 19xx and that I last saw h~~e~~r alive on May 15 19xx.

Immediate cause of death Cardio Vascular Disease. — Duration ?

Due to Cerebral Hemorrhage — Duration 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 928 Cathedral Date signed 5/20/44

G 17301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17301 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Archer St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Archer St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dollie Gregg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife James Gregg
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1899

8. AGE: Years	Months	Days	If less than one day
45	4	3 28	hr. min.

9. Birthplace Kingstree S C
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Levy Washington
13. Birthplace Kingstree SC

MOTHER
14. Maiden Name Martha ?
15. Birthplace Kingstree S C

16 (a) Informant Martha Washington
(b) Address 510 Archer St

17 (a) Burial (b) Date thereof May 20 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 419 North Mount St Rear

19 (a) (Date received by local registrar) MAY 18 1944 (b) Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1944, at 6301 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1943, to May 17 1944 and that I last saw her alive on 5-15 1944

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M.D.
M. D.
453 Dolphin St Date signed 5-17-44

G 17302 ✓ G 17302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12|a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20. 1900

8. AGE: Years 44 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Tarboro N C (Town, county, and state)

10. Usual Occupation Tobacco Worker

11. Industry or business

FATHER 12. Name Joseph Jenkins
13. Birthplace Tarboro N C

MOTHER 14. Maiden Name Lousie Baker
15. Birthplace Wilson N C

16 (a) Informant Frank Jones
(b) Address 620 So Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21. 1944 (month) (day) (year)
(c) Cemetery or crematory Tarboro N C
Location

18 (a) Funeral director Joseph A. Singley
(b) Address 401 North Mount St

19 (a) (Date received by Registrar) MAY 18 1944 (b) Registrar

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944 at 6:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 19 44 to May 17 19 44, and that I last saw h[illegible] alive on May 17 19 44

Immediate cause of death Hypertensive Heart Disease — Duration

Due to

Due to

Other Conditions Chronic Nephritis & Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hospital Date signed May 17, 44

Huntington Williams, M.D.

G 17303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 17303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Agnes Hospital
(c) Hospital or institution Baltimore Md (2) Ward 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State of Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Infant never resided 217 S. Grundy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby James.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Infant
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day
Died several hrs after delivery hr. 2 hrs min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jennie Foster
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof May 18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Mt. Carmel Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

MAY 18 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 19 44 to 5/17 19 44, and that I last saw h[illegible] alive on 5/17 19 44

Immediate cause of death Premature

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Nathan E Lebrode M. D.
Address St Joseph's Hospital signed 5/17/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115 C

Registered No. 17304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and Johns Streets
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 No. Calvert Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Virginia Winters

3 (b) If veteran, name war — W
3 (c) Social Security Account No. NONE
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Robert Winters
6 (c) If alive, give age 28 years
7. Birth date of deceased (mo., day, yr.) Feb. 29, 1924
8. AGE: Years 20 | Months 2 | Days 18 | If less than one day ... hr. ... min.
9. Birthplace Turner's Sta. Balto. County, Md. (Town, county, and state)
10. Usual Occupation Zell Motor Car Co., Balto.
11. Industry or business Clerical work

FATHER
12. Name George Mayhew
13. Birthplace England

MOTHER
14. Maiden Name Virginia Morris
15. Birthplace Baltimore

16 (a) Informant Florence Dietzway (Sister)
(b) Address 604 Melville Ave, Baltimore
17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery Woodland Park
Location Parkville Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 MAY 18 1944 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 2 20 PM
21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944, to May 17 1944, and that I last saw her alive on May 17 1944.

Immediate cause of death	Duration
Due to Cardiorespiratory failure	
Due to Anaesthesia (Nitrous oxide, ether, oxygen)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 17 1944
Major findings of operation: Chronic infection, tonsillar tags
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? (Specify type of place)
(e) Means of injury
23. Signature James N. McCosky, Jr. M.D. M. D.
Address Women's Hospital Date signed 5-17-44

VS 3

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos., 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Llewelyn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvin Shaeffer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1878

8. AGE: Years 65 | Months 9 | Days 9 3 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Baltimore Cemetery

FATHER 12. Name David M. Shaeffer
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Julia A. (Unknown)
15. Birthplace Md

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Union
Location Carroll Co. Md

18 (a) Funeral director Tillson & Son
(b) Address 324 E. Coul St

MAY 18 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16 1944, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1943, to 5-16 1944, and that I last saw h[illegible] alive on 5-16 1944.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	4 yrs.
Due to	
Due to	
Other Conditions Pneumonia	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Pratt M.D.
Address B.C.H. Date signed 5/16/44

G 17306 G 17306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. H 4706

1226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Curtis Bay Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Elmtree St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Stanley J. Cheswick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-15-08

8. AGE: Years 36 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation W. Md. R.R.

11. Industry or business

FATHER 12. Name Joseph Cheswick
13. Birthplace Poland

MOTHER 14. Maiden Name Stella ?
15. Birthplace Poland.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location.....

18 (a) Funeral director Leonard J. Rus
(b) Address 205 Huntington Ave Wilmington, Del

19 (a) MAY 18 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1[illegible]

21. I certify that death occurred on the date stated, at 2:55 P.M.
ed deceased from May 16 1944.
and that I last saw him alive on May [illegible]

Immediate cause of death
Complete Intestinal Obstruction
Due to.....
Due to.....

Other Conditions Colectomy performed Feb 1943 for Ulcerative colitis
(Include pregnancy within 3 months of death)
Date of operation 5/16/44
Major findings of operation: Entire small bowel nonviable
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature George M. Hamps, M. D.
Address Johns Hopkins Hosp Date signed 6/17

17307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 17307

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Goodwood Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Goodwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Willing

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lenore L. Willing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1872

8. AGE: Years	Months	Days	If less than one day
72	2	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Mariner - B. & A. Penna
11. Industry or business

FATHER
12. Name William Willing Sr
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Lenore L. Willing
(b) Address 2709 Goodwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location

18 (a) Funeral director Leonard J. Funk
(b) Address 5305 Harford Rd

19 (a) (Date received by registrar) (b) Registrar

MAY 18 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 15 1944 to May 17 1944
and that I last saw h[illegible] alive on May 16 1944

Immediate cause of death Pulmonary Edema — Duration 2 days
Due to Nephritis - Vascular disease — ?
Due to — ?
Other Conditions Apoplexy — 1940
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Palmer Hall MD
Address 1961 Eutaw Pl Date signed May 17/44

G 17308 — BALTIMORE CITY HEALTH DEPARTMENT — G 17308 Registered No.

CERTIFICATE OF DEATH 92D

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 HARFORD AVE
(c) Hospital or institution: NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 5502 ELSRODE ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET REARDON. (Margaret C.Reardon)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Aug. 10th 1868

8. AGE: Years 75 | Months 9 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Phillip Reardon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Riordon
15. Birthplace Ireland

16 (a) Informant Julia A.O'Sullivan
(b) Address 5502 Elsrode Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

MAY 18 1944 (b) ... Registered by registrar ... Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH MAY 16 1944 19 ... at 5.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 4 1944 to MAY 16 1944 and that I last saw her alive on MAY 16 1944

Immediate cause of death	Duration
APOPLEXY MAY 14	1944
CHRONIC MYOCARDITIS	1940
Due to ARTERIOR SCLEROSIS	1940.
Due to CHRONIC ARTHRITIS DEFORNAM	1940
Other Conditions	

(Include pregnancy within three months of death) NONE
Date of operation
Major findings of operations: NONE
of autopsy: NONE

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. P. Reardon
Address 3013 SAINT PAUL STREET Date signed MAY 16 M. D. 1944

G 17309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17309 / 937 Registered No.

99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 N. Spring Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hagner

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Antone Hagner

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 24th, 1869

8. AGE: Years 74 | Months 4 | Days 20 | If less than one day ##### hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Vomastek
13. Birthplace Austria

MOTHER
14. Maiden Name Maria Belischek
15. Birthplace Austria

16 (a) Informant Miss. Margaret A. Hagner
(b) Address 1506 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) ____ (Date rec'd by registrar) (b) ____

MAY 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th. 1944, at 4 P. M

21. I certify that death occurred on the date above stated, that I last attended deceased from APR 6 1944 to MAY 14 1944, and that I last saw h[illegible] alive on MAY 14 1944

Immediate cause of death General Depression — Duration 12 hrs

Due to Hypertention Myocarditis — Duration (2)

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____
(e) Means of injury ____

23. Signature Otto H. Duker M. D.
Address 928 E. North Ave Date signed MAY 15 19

454058 C 17310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

C 17310 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. ARUNDEL
(c) City or town GLENBURNIE
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rufus Briscoe
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: BLACK | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-20-28
8. AGE: Years 15 | Months 10 | Days 26 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Jim Briscoe
13. Birthplace
MOTHER: 14. Maiden Name Lottie Macey
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 / 19 / 44 (month) (day) (year)
(c) Cemetery or crematory Marley Ct
Location Marley Neck Rd-Md
18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St.,
(a) MAY 18 1944 (b) Filed rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 11 1944 to MAY 16 1944 and that I last saw h/M alive on MAY 16 1944.

	Duration
Immediate cause of death: Rheumatic Heart Disease	1yr
Due to: Rheumatic Fever	1yr
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Kenneth Ford M. D.
Address Johns Hopkins Date signed 5-16

G [redacted] 17311 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G [redacted] G 17311

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 542 N. Fremont Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Fremont Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1878

8. AGE	Years	Months	Days	If less than one day
65	65	7	2	hr. min.

9. Birthplace Lancaster Co. Va.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Robert Fleming
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Annie Yates
15. Birthplace Lancaster Co. Va.

16 (a) Informant Estelle Fleming
(b) Address 15 S. Yewdall St. Phila. Pa.

17 (a) Burial (b) Date thereof May 18, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Phila., Pa.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) [illegible] Registrar

MAY 18 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16- 1944, at 10:20 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Cardio-vascular Renal Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5/16/44

(OVER)

C 17312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17312 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co.
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. Beaver Dam Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Long

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 13, 1944
8. AGE: Years | Months: 8 | Days: 5 | If less than one day: hr. min.
9. Birthplace: Cockeysville, Md. (Town, county and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name: Thomas Leonard Long
13. Birthplace: Balto Co.

MOTHER
14. Maiden Name: Virginia Ford
15. Birthplace: Balto Co.

16 (a) Informant: Mr Thomas L. Long
(b) Address: Cockeysville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21, 1944 (month) (day) (year)
(c) Cemetery or crematory: Prospect Hill
Location: Chestnut Ridge, Balto Co, Md

18 (a) Funeral director: London M. Sparks
(b) Address: Sparks.

19 (a) (b) Huntington Williams, M.D.

MAY 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944 to May 18 1944, and that I last saw h[illegible] alive on May 18 1944

	Duration
Immediate cause of death: Peripheral circulatory collapse	
Due to: Acute febrile disease (meningitis?)	3 days
Due to:	
Other Conditions: Acute pulmonary edema. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. Ray W. Tutt M. D.
Address: University Hosp. Date signed 5/10/44

G 17313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 17313

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 FAIT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 FAIT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. KNAPP

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:
4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MARY KNAPP
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JUNE 6 1884
8. AGE: Years 59 | Months 11 | Days 9 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CAR REPAIRER
11. Industry or business BETH. STEEL CO.

FATHER
12. Name MORRIS KNAPP
13. Birthplace GERMANY

MOTHER
14. Maiden Name CHRISTINA ZORN
15. Birthplace GERMANY

16 (a) Informant MARY KNAPP (WIFE)
(b) Address 3900 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 19/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) MAY 18 1944 Huntington Williams Registrar

VS 100

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH MAY 15 19 44 at 10/30

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 19 44 to May 15 19 44 and that I last saw h[illegible] alive on May 12 19 44

Immediate cause of death: Coronary Thrombosis — Duration 1944
Due to: Chronic Myocarditis — Duration 1944
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 3505 Dad[illegible] Date signed 5/16/44

Burial 17314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 17314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 FOSTER AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 FOSTER AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEONILLA J. KALBFLEISCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife GEORGE A. KALBFLEISCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 16 1888

8. AGE: Years	Months	Days	If less than one day
56	1 0	0 29	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ALPHONSE NOEL
13. Birthplace FRANCE

MOTHER
14. Maiden Name ELIZABETH BORNHERN
15. Birthplace GERMANY

16 (a) Informant GEORGE A. KLABFLEISCH (HUS)
(b) Address 3312 FOSTER AVE.

17 (a) BURIAL (b) Date thereof MAY 19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiken INC
(b) Address 403 N. WOLFE ST.

19 (a) (Date received by registrar) (b) Huntington Mills Md.

MAY 18 1944 VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 15 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944, to May 11 1944, and that I last saw her alive on May 15 1944.

Immediate cause of death: Cerebral Haemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C. Ruhrah, M. D.
Address 3139 E. Baltimore Date signed 5-16-44

Approved for H. L. Willenbucher M.D. 5/16/44 per Robert Lee Graham M.D.

G 17315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17315 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2861 PHILA AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2861 PHILA. AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL GEBHARDT

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: CATHERINE GEBHARDT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 23 1860

8. AGE: Years 83 | Months 3 | Days 21 | If less than one day: 22 hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation RETIRED GROCERYMAN

11. Industry or business FOR SELF

FATHER
12. Name MICHAEL GEBHARDT
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant FREDERICK T. GEBHARDT (SON)
(b) Address 2861 PHILA. AVE.

17 (a) BURIAL (b) Date thereof 5/20/44
(Burial, cremation, or removal) (month) (day) (year)
MAY 20 1944
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b)
Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 15 1944 at 5/45 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944, to May 15 1944, and that I last saw alive on May 15 1944.

Immediate cause of death: Uremia (Myocardial Cardiac Asthma) — Duration: 10 yrs 2 days

Due to: Hypertension — 10 yrs ½

Due to: Arteriosclerosis — 10 yrs ?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Dorsch M. D.
Address 2530 E. Baltimore St. Date signed 5/16/44

Erase #6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6 17316

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Master

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location PUBLIC CEMETERY MAY 18 1944

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 18 1944 Huntington Williams M.D.
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3, 1944, to May 3, 1944, and that I last saw him alive on May 3, 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dorsey Rosedale, M. D.

Address University Hospital Date signed 5/3/44

17317 Issue #5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183 Registered No. G 17317

1. PLACE OF DEATH: Found Foot of
(a) Baltimore City, Maryland
(b) Street address Lancaster St.
(c) Hospital or institution: Balto. City Harbor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Beaumont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAY 18 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) MAY 18 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12- 1944, at 1.35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 16 at 2/3 ? M.
(b) Where did injury occur? Harbor, fig Lancaster St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found drowned

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 5/13/44

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G 17318~~ Grave #7 BALTIMORE CITY HEALTH DEPARTMENT Grave
CERTIFICATE OF DEATH ✓ 183 Registered No. G 17318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Morgue
(c) Hospital or institution Found Pier #7 Locust Point
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Helfred Reiss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ingrid Reiss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Cremation (b) Date thereof 6/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY MAY 18 1944

18 (a) Funeral director

(b) Address 1217 St. Paul St.

19 MAY 18 1944 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1944 at 11½ M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5/12/44 at 24/1 M.

(b) Where did injury occur? Pier #7 Locust Point

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.

Date signed

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17319 BALTIMORE CITY HEALTH DEPARTMENT G 17319
CERTIFICATE OF DEATH 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4202 Belvieu Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Belvieu Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert W. Boss

3 (b) If veteran, name war

3 (c) Social Security Account No 214-01-1496

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Anna Boss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th 1879

8. AGE: Years 64 | Months 11 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Balto. Supply Co

FATHER
12. Name Robert D. Boss
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Butler
15. Birthplace Md.

16 (a) Informant Anna Boss
(b) Address 4202 Belvieu Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

MAY 18 1944

19 (a) ... (b) ... (Date rec'd by registrar) ... Registrar Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th 1944 at 12 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to May 15 1944, and that I last saw him alive on May 15 1944

Immediate cause of death	Duration
carcinoma of rectum	14 mths
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1944
Major findings of operation: carcinoma.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1720 East 20 Date signed 5/19/44 M. D.

G 17320 G 17320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Avenue
(c) Hospital or institution:
Home for the Aged-Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Alice Forsythe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 7, 1870

8. AGE: Years 74 | Months - | Days 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Capt. Charles H. Lewis
13. Birthplace: Kent County, Maryland

MOTHER
14. Maiden Name: Sarah Abey
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Miss A. V. Savage
(b) Address: 2211 W. Rogers Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

MAY 18 1944 (Date rec'd) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY - 17 1944, at 10:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY-10 1944 to MAY 16 1944 and that I last saw h[illegible] alive on MAY 16 1944

Immediate cause of death: Coronary thrombosis — Duration: 4 hours
Due to:
Due to: Arteriosclerosis — 10 yrs
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Archie J. Davis M. D.
Address 800 N 33rd St Date signed 5-18-44

17321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113

Registered No. G 17321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5, East Heath St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence N Arvell (Clarence D. Narvell)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9814

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1895

8. AGE: Years 49 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)

10. Usual Occupation Shop Salesman

11. Industry or business

FATHER: 12. Name Oliver Narvell
13. Birthplace Cecil Co. Md.

MOTHER: 14. Maiden Name Bessie Baxton
15. Birthplace Cecil Co. Md.

16 (a) Informant Elizabeth Narvell
(b) Address 5, E. Heath St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5, 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Flynn and Fleming
(b) Address 1426 Light Street

MAY 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 1944 to 5/18 1944, and that I last saw h.im alive on 5/11 1944.

Immediate cause of death: Bullous emphysema of Right lung — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Steinberg

Address 5 East Heath Date signed 5/18

VS 150

M. STEINBERG, M.D.

17322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 17322

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Kingsway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Kingsway Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Hellman

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Daisy Hellman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1878

8. AGE: Years 65 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business South Eastern Ship Yard

FATHER
12. Name William A. Hellman
13. Birthplace --

MOTHER
14. Maiden Name Katherine Johnson
15. Birthplace --

16 (a) Informant Mrs. Cordelia Nickel
(b) Address 1511 Kingsway Rd. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) MAY 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 15, 1944, at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to May 15 1944 and that I last saw h[illegible] alive on May 15 1944

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Seamon Bldg Date signed May 18-44

G 17223 ✓ G 17223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or institution (yrs., mos., or days) 15 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Keyworth Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Shlian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1925

8. AGE: Years 18 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Receiving Clerk

11. Industry or business

FATHER
12. Name Benjamin Shlian
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Rose Shlian
(b) Address 2813 Keyworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1713 E. Balto. St

19 (a) MAY 19 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 5:05 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereof, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury 5-17-44 at 5 P.M. 4/1 Baltimore Co.
(b) Where did injury occur? 311 W. Baltimore St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Head was crushed in elevator shaft.

23. Signature H. L. Hollenworth M.D. (Medical Examiner)
Date signed May 18, 1944.

Huntington Williams, M.D.

VS 151

correct age is especially important. Physicians: please write the

G 17324 ✓ G 17324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 LAKE DRIVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 LAKE DRIVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACK LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0542

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife HANNAH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 15, 1883

8. AGE: Years	Months	Days	If less than one day
60	8	2	hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation FUNERAL DIRECTOR
11. Industry or business

FATHER
12. Name LEMUEL LEWIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name JENNIE HORRINGER
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-19-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO. + CONKLIN ST

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St

19 (a) MAY 19 1944 (Date received by registrar) Huntington Willard, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-44 19 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 19 44 to May 17 19 44, and that I last saw h[illegible] alive on May 17 19 44.

Immediate cause of death: Coronary Occlusion — Duration
Coronary Artery Disease.
Due to
Due to
Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Rimokoff
Address Temple Gardens Chapel Date signed May 18, 1944

17325 ✓ G 17325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 E. BIDDLE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 E. BIDDLE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM KRAVETZ

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife REBECCA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21-1881 1882

8. AGE: Years	Months	Days	If less than one day
62	9	26	hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business

FATHER
12. Name ELIAS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name LEAH
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-19-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO + CONKLIN ST

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) MAY 19 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-44 19 , at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1944 to 5-17- 1944 and that I last saw h.im alive on 5-17- 1944

Immediate cause of death: Coronary Occlusion — Duration: 10 min.

Due to: Coronary Insufficiency — 3 mo.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paloma Herman, M. D.
Address 2424 Eutaw Place Date signed 5-18-44

(over)

G 17326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G 17326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William L Sweetman

3 (b) If veteran, name war

3 (c) Social Security Account No. 206-03-5522

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Pearl Upston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1897

8. AGE: Years 47 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Washington D.C (town, county, and state)

10. Usual Occupation Labor

11. Industry or business B&O Railroad

FATHER
12. Name Samuel Sweetman
13. Birthplace Washington D.C

MOTHER
14. Maiden Name Katherine Lucas
15. Birthplace Washington D.C.

16 (a) Informant Paul Sweetman (Brother)
(b) Address 3306 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md

18 (a) Funeral director J. Melville Jenkins
(b) Address 27 W Kirk Ave

19 (a) Received MAY 19 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 , at 7 P. M

21. I certify that I took charge of the remains described above, held an Partial autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/16/44 at 5:30 P. M. 20-6
(b) Where did injury occur? 100' south of Liverpool Pub Baltimore
(c) Did injury occur at home, on farm, industrial place or in public place? public While at work? no
(d) Means of injury Struck by P.R.R. Train

23. Signature Robert L. Fraser M.D. Medical Examiner.
Date signed May 17 1944

G 17327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. G 17327

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 W 34th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 W 34th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lettie B. Brewer.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Pleasant W. Brewer

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1877

8. AGE: Years 66 | Months 5 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland. (town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Pleasant W. Brewer.
(b) Address 616 W 34th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Thanner & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) MAY 19 1944 (Registrar's signature) Huntington Williams, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944 to May 17 1944 and that I last saw h[illegible] alive on May 17 19 44

Immediate cause of death	Duration
Carcinoma Cachexia	1 month
Due to Carcinoma of Uterus	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Herbert M. Foster M. D.
Address 2824 St. Paul St. Date signed May 18, 44

G 17328 ✓ G 17328

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Clifton Park terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Clifton Park terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wesley Wood

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Wood
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 21 1879

8. AGE: Years 64 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Continental Can Co
11. Industry or business Foreman

FATHER
12. Name Charles Wood
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Parker
15. Birthplace W. Va

16 (a) Informant Mrs. Grace Wood
(b) Address 2908 Clifton Park terra

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2002 E. Baltimore St

MAY 19 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1943 to May 17 1944, and that I last saw h[illegible] alive on 5-17-1944

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to Carcinoma of L. Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw Pl. Date signed 5-17-44

(17)

G 17329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

✓ G 17329

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 De Soto Road
(c) Hospital or institution:

25-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 De Soto Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen W. Braun

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Paul Braun
6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): June 3. 1875

8. AGE: Years 68 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business

FATHER
12. Name: August Griesner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany.

16 (a) Informant: Paul Braun
(b) Address: 1809 De Soto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 20. 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave

18 (a) Funeral director: Mrs. Nus. John W. Teufel & Son
(b) Address: 801 W. Lafayette St.

19 (a) (b) Huntington Md

MAY 19 1944

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1944. at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1934. to May 16 1944. and that I last saw he alive on May 16 1944

Immediate cause of death: Coronary Occlusion — Duration: 4/12 hrs

Due to: Arteriosclerosis, hypertension — Duration: ?

Due to: Cardio vascular Disease

Other Conditions: Cardiac Hypertrophy + Mitral Insufficiency — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature: Carl Koerting M. D.
Address: 326 W. Lombard St. Date signed: 5/17/44

G 17230 ✓ G 17230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1545 Abbottston Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 Abbottston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Isabelle Webster

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Archie I. Anson Webster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1867

8. AGE: Years 77 | Months 1 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward C. Deppish
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah Duhurst
15. Birthplace Baltimore

16 (a) Informant Archie I. Webster, Jr.
(b) Address 2329 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) MAY 19 1944 — Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 11:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to May 16 1944; that I last saw her alive on May 16 1944

Immediate cause of death: Cerebral Hemmorhage 12 hrs
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 3001 Sherwood Ave Date signed May 16-44

G 17331 G 17331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 S. Decker Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Greenefelder (Margaret Rudd Kirby)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: ?

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1916

8. AGE: Years 27 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John P. Kohlhepp
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Chamberlain
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary Kohlhepp
(b) Address 4209 Mary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-44 (month) (day) (year)
(c) Cemetery or crematory St. Pauls 5th Ref. Church Cemetery
Location Balto. Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date received by Registrar) MAY 19 1944 (b) Huntington for Baltimore, Md. Registrar

VS 151

correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull, rupture of liver and spleen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/16/44 at 9 P. M.
(b) Where did injury occur? Carlin's Park, Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fall from "Racer Dip"

23. Signature Robert L. Gretha M.D.
Medical Examiner.
Date signed May 17 1944

G 17332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17332 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Dist-Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Harview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August William Diehl

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-10-7813

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther Mae Moffit

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 28, 1888

8. AGE: Years	Months	Days	If less than one day
59	9	20	hr. min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual Occupation Sales manager

11. Industry or business Funk & Ennis

FATHER
12. Name John Diehl
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Reinecke
15. Birthplace Baltimore, Co.

16 (a) Informant Esther M. Diehl
(b) Address 3116 Harview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) MAY 23 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1947, at 1 10 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Chester F. Lubin M.D. Medical Examiner.
Date signed 5/24/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 17333

No. 17333 - 87518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 McAleer Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Franklin Cornell

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Gertrude Garrison
6 (c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): June 4, 1864

8. AGE: Years: 79 Months: 11 Days: 14 If less than one day: hr. min.

9. Birthplace: Prince William Co. Va. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Retired 8 years

FATHER
12. Name: John F. Cornell
13. Birthplace: Va.

MOTHER
14. Maiden Name: Mary Syncox
15. Birthplace: Va.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-44 (month) (day) (year)
(c) Cemetery or crematory: Moreland
Location: Baltimore

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) Huntington, Md. (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18 1944, at 4.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-18 1944 to 5-18 1944, and that I last saw h~~e was alive~~ on 5-18 1944

Immediate cause of death	Duration
Bronchopneumonia	1 wk
Due to Cirrhosis	
Due to Benign Prostatic Hypertrophy	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: B. B. Leet
Address: Balto City Hosp Date signed: 5-18-44 M. D.

G 17334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17334 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4533 Schenley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 37 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4533 Schenley Road (If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Price Parker

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-7951

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda M. Parker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21-1893

8. AGE: Years 50 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Robert Royston Parker
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy A. Denver
15. Birthplace Alabama

16 (a) Informant Mrs. Hilda M. Parker
(b) Address 4533 Schenley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) MAY 19 1944 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18. 1944, at 6:17 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1944 to 5-18 1944 and that I last saw h[illegible] alive on 5-17- 1944

Immediate cause of death Pneumonia — Duration 4 days

Due to Hypertensive Cardio Vascular Renal disease — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify nature of place)
(e) Means of injury
13. Signature [signature] M.D.
Address 1901 Eutaw Date signed May 19/44

VS 150

G 17335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 17335 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Roland Avenue
(c) Hospital or institution:

12-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Elizabeth Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William A. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1- 1853

8. AGE: Years 91 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name John Christmas
13. Birthplace England
14. Maiden Name Mary E. Barnes
15. Birthplace England

16 (a) Informant Mrs. Elsie Elizabeth Bowers
(b) Address 3919 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20-1944 (month) (day) (year)
(c) Cemetery or Crematory Mt. Moriah Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b)
Registrar
MAY 19 1944
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944, to May 17 1944, and that I last saw h[illegible] alive on May 17 1944

Immediate cause of death — Duration

Due to Cerebral and general atherosclerosis — 2

Due to — 3 dys

Other Conditions Cerebral hemorrhage
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
M. D.
Address 8429 Charles St. Date signed 5/19/44

G 17336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G 17336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Wise
13. Birthplace Va

MOTHER
14. Maiden Name Stokes
15. Birthplace Va

16 (a) Informant Robert Scott
(b) Address 815 N Wolfe St

17 (a) (Burial, cremation, or removal) (b) Date thereof May 21 1934 (month) (day) (year)

(c) Cemetery or crematory
Location Farmville Va

18 (a) Funeral director Robt E Williams
(b) Address 1515 McCulloh St Huntington Building

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 19 1934

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1934, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rheumatic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenmuller M.D. Medical Examiner.
Date signed May 18, 1934.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

b 17337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G 17237

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and name town)
(d) Street No. 325 N. High Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Kuntz

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1893

8. AGE: Years 50 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation City Employee

11. Industry or business

FATHER
12. Name James Kuntz
13. Birthplace Czec.

MOTHER
14. Maiden Name Hajek
15. Birthplace Czec

16 (a) Informant Mary T. Michael
(b) Address 964 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison St.

19 (a) (Date received by registrar) MAY 19 1944 (b) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944, at 10:05 P. M.

21. I certify that I took charge of the remains described above, held an Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of Chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-17-44 at 9:45 P. M.
(b) Where did injury occur? about 320 ft. E. of Edmonson Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed May 18, 1944.

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G 17238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 17238 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4542 E. Bowleys Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 4542 E. Bawleys Lane (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine M. Pospisil

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced.: married

6 (b) Name of husband or wife Joseph F. Pospisil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22, 1877

8. AGE: Years 66 | Months 6 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER
12. Name Michael Hlavac
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Havlik
15. Birthplace Czechoslovakia

16 (a) Informant Joseph F. Pospisil (Husband)
(b) Address 4542 Bowleys Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAY 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1944 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1942 to May 16 1944, and that I last saw him alive on May 16 1944.

Immediate cause of death: Cardiac failure — Duration: 2 hrs.
Due to: Metastatic Carcinoma of Stomach — Duration: 2 yrs.
Due to: — Duration:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L B Stevens M. D.
Address 3400 Erdman Ave. Date signed 5/18/44

Huntington Williams M.D.

G 17339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17339 / 13 B

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1542 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Northern Swann

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: late Ida Berry

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1848

8. AGE: Years 95 | Months 4 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Northumberland Va (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va.

MOTHER
14. Maiden Name Schmidty
15. Birthplace Va.

16 (a) Informant Edward Swann
(b) Address 2606 E. Preston. Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)

(c) Cemetery or crematory
Location Lilian County, Va.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison Street

19 (a) (b) Registrar

MAR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 10, 1944 to May 18 1944 and that I last saw him alive on May 17 1944

Immediate cause of death: Chr. Nephritis

Due to

Due to

Other Conditions Chr. Myocarditis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Hammond M.D.
Address 720 Medical Arts Bldg Date signed 3/15/44

G 17340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1925

Registration No. 45240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 N. Maderia St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 N. Maderia St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerry Fuka

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16 1899

8. AGE: Years	Months	Days	If less than one day
44	6	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation City Employer
11. Industry or business Highway Dept.,

FATHER
12. Name Late Joseph Fuka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Petr
15. Birthplace Czechoslovakia

16 (a) Informant Frank J. Fuka (brother)
(b) Address 925 N. Maderia St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison St.

19 (a) (Date received by registrar) (b) Registrar

MAY 19 1944 Huddington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
Mitral Stenosis (Rheumatic)	1 yrs
Due to acute Pulmonary Edema	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. Fuka
Address 600 N. Dulaney Valley Date signed May 19 1944 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G AB-49041 — G 17341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 S. Bonsal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Benjamin Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1874

8. AGE: Years 69 | Months 9 10 | Days 24 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathaniel Wallace
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Ann Craig
15. Birthplace Ohio

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director John R. Hudson
(b) Address 3000 E. Balto. St.

19 (a) (Date rec'd by registrar) (b)

MAY 19 1944

Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, at 5.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1944, to 5-17 1944, and that I last saw h[illegible] alive on 5-17 1944.

Immediate cause of death: Intestinal Obstruction — Duration: 48h

Due to: Atherosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-16-44

Major findings of operations: Intest. Obst.

of autopsy: Denied

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Stitt M. D.
Address Balto City Hosp Date signed 5.18.44

1843 Lawrence

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G 17342

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1018 N. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 N. Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Andrew Gaines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1874

8. AGE: Years	Months	Days	If less than one day
69 70	7	2	hr. min.

9. Birthplace Balto., Md. (Town, County, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Richard Gaines

13. Birthplace Maryland

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Irene Gaines

(b) Address 1018 N. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Md.

Location Baltimore

18 (a) Funeral director Mrs. Lucy H. Holland

(b) Address 1631 Druid Hill Ave.

MAY 19 1944 (Date rec'd by reg.)

19 (a) Hemmington Williams M.D. (b) Attendant

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at 7.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11-1944, to 5-15-1944, and that I last saw him alive on 5-15-1944

Immediate cause of death Mitral Insufficiency — Duration

Due to Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Mansell Lawrence M. D.

Address 1032 W. Lanvale Date signed 5/18/44

7343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. 17343

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hampton White

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1905

8. AGE: Years	Months	Days	If less than one day
39	4	16	hr. min.

9. Birthplace Lancaster Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Albert White
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Lucy Taylor
15. Birthplace Lancaster Co. Va.

16 (a) Informant Lucy White
(b) Address 1618 Pennsylvania Ave.

17 (a) Buried (b) Date thereof May 19, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Lancaster Co. Va.

18 (a) Funeral director Mrs. Geo. A. Holland
Address 1631 Druid Hill Ave.

19 MAY 19 1944
(Date rec'd by registrar) Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944, 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944, to May 17 1944, and that I last saw h[illegible] alive on May 17 19 44.

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Baptiste M. D.
Address Provident Hospital Date signed 5/19/44

VS 150

7344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

301

Registered No. G 17344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Upton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 95

8. AGE: Years 49 48 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ed Bailey
13. Birthplace Va

MOTHER
14. Maiden Name Carrie Clayton
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5/20/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. Ave & Co. Md
18 (a) Funeral director Chas. W. Alexander
(b) Address 927 N. Mount St.

19 (a) MAY 19 1944 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to May 17 1944 and that I last saw h[illegible] alive on May 17 1944

Immediate cause of death: lobar pneumonia c bacteremia - type 12 — Duration

Due to: Aortic insuff due to syphilitic aortitis

Due to: Hypertensive cardiovascular disease; auricular fibrillation cardiac manifestation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address JHH Date Signed 5/19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 17345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

G 17345 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, ~~Maryland~~ Washington Apts.
(b) Street address Chas. St. & Mt. Vernon Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Virginia Laucks Buckingham

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Wm. A. Buckingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1861

8. AGE: Years	Months	Days	If less than one day
82	7	15	hr. min.

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Israel Laucks
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Imilda Wilt
15. Birthplace York, Pa.

16 (a) Informant Mrs. E. Ernest Woollen
(b) Address Washington Apts.

17 (a) Burial (b) Date thereof 5/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Prospect Hill
Location York, Pa.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 2900 Eutaw Place

19 (a) (b) Huntington Williams, M.D.
(Signature of local registrar)

MAY 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1935 to May 18 1944, and that I last saw her alive on 5-17 1944.

Immediate cause of death Uremic Coma — Duration 3 days
Due to Chronic Nephritis — 3 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 1123 St. Paul St. Date signed

17346

TO #67901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

✓ G 17346

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs. 40 min.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1337 N. Fremont Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1944

8. AGE: Years	Months	Days	If less than one day
			17 hr. 40 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER

12. Name Melvin

13. Birthplace Md.

MOTHER

14. Maiden Name Elizabeth Lee

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)

(c) ~~Cemetery or~~ crematory

Location 4940 Eastern Ave

18 (a) Funeral director Balto. City Hosp.

(b) Address

19 MAY 19 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1944 11:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1944 to 5-10 1944 and that I last saw her alive on 5-10 1944

Immediate cause of death Intra-cranial hemorrhage

Due to Birth injury??

Due to prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. C. Quadlbf. M.D.

Address Balto. City Hosp. Date signed 5-10-44 M. D.

17347

YA-57721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G 17347 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1823 Filbert St.-Curtis Bay (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Ranalds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1944

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER 12. Name Harold Ranalds

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name Mary Wilson

MOTHER 15. Birthplace Ohio

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5-17-44 (month) (day) (year)

(c) Cemetery or crematory Balto City Hospitals Location 4940 Eastern Avenue

18 (a) Funeral director

(b) Address

19 MAY 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1944 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1944 to 5-4 1944, and that I last saw him alive on 5-4 1944.

Immediate cause of death: Intra cranial hemorrhage — Duration:

Due to Birth injury

Due to

Other Conditions Pre-eclampsia Severe, maternal (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pending

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Russell Bd. M. D.

Address Balto City Hosp Date signed 5-4-44

G 17348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G 17348 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willis Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
C	M	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Lillie Williams
(b) Address 912 W. Fayette St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 19 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn St
Location

18 (a) Funeral director Mary Katie Wiseman
(b) Address 322 Schroeder St.

19 (a) MAY 19 1944 (b) Filed Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13/44 19, at 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry-Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Hyaceolized Degeneration
Syphylis
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Upton Lubinski M.D. Medical Examiner.
Date signed 5/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 McAleer Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 McAleer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Ryer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1895

8. AGE: Years	Months	Days	If less than one day
48	5	11	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Wm. Ryer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Johanna Metz
15. Birthplace Amsterdam, Holland

16 (a) Informant Wm. A. Ryer, Son
(b) Address 1510 S. Charles St. Balto. 30 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St. Balto. Md

19 (a) 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1944, to May 17 1944, and that I last saw h[illegible] alive on May 17 1944

Immediate cause of death: Edema
a Acute Pulmonary Edema
Hypertensive Cardio-Vascular Dis. 10 yrs.
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration
1 hour
10 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Ashman M. D.
Address 1201 Poplar Grove St. Date signed 5/19/44

G 17350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 17350
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5011 Broadmoor Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. Gordon Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. GISRIEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1863

8. AGE: Years	Months	Days	If less than one day
80	8	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerk of U. S. Treasury
11. Industry or business Retired 10 Yrs.

FATHER
12. Name Jacob Gisriel
13. Birthplace Alsacey Lorraine

MOTHER
14. Maiden Name Sarah Berger
15. Birthplace Baden-Baden, Germany

16 (a) Informant Mrs. James C. Callis
(b) Address 5011 Broadmoor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 19 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1944 to May 17 1944
and that I last saw h alive on May 19 1944

Immediate cause of death	Duration
Cerebral Hemorrhage.	2 wks.
Due to	
Due to Hypertension & Arterio sclerotic disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Specify yes or no)
(e) Means of injury

23. Signature Henry Sharrer M. D.
Address 3217 York Rd Date signed 5/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 1735 | BALTIMORE CITY HEALTH DEPARTMENT | C 17351 Registered No.

CERTIFICATE OF DEATH 47

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2852 Mayfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2852 Mayfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. Knight

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-4426

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Dorothy E. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28th 1909

8. AGE: Years	Months	Days	If less than one day
35	1	19	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Steam Fitter
11. Industry or business Standard Engineering Corp

FATHER
12. Name Taylor Knight
13. Birthplace Va

MOTHER
14. Maiden Name Sadie Owen
15. Birthplace Va

16 (a) Informant Lorraine B. Wentz
(b) Address 4613 Minnesota Ave

17 (a) Burial (b) Date thereof 5/20/44 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery ~~or Crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (b)
Huntington Williams M.D. Registrar

MAY 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29- 1944 to 5-17- 1944 and that I last saw him alive on 5-17- 1944.

Immediate cause of death Carcinoma of right Lung — Duration 4 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton A. Lang M. D.
Address 2117 Belair Date signed 5-18-44

D 17352 ✓ G 17252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Aisquith st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Aisquith st (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Kate Leach

3 (b) If veteran, name war N
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Harry L. Leach
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 29th 1867

8. AGE: Years 76 | Months 6 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Hugh Campbell
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Ireland

16 (a) Informant William T. Woodward
(b) Address 1105 Aisquith St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams M.D. Address 100 N. Mulberry

MAY 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1944, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1944, to May 16th 1944, and that I last saw h~~e~~ alive on May 16th 1944.

Immediate cause of death ..... Duration

Cardio vascular disease ..... 2.

Due to hypertension ..... 2.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature H. J. Sanders M. D.
Address 100 N. Mulberry Date signed May 18 1944

G 17353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Farquar Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1924

8. AGE: Years 20 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business Federal Housing

FATHER
12. Name M. W. Tucker
13. Birthplace North Carolina

MOTHER
14. Maiden Name Minnie Taylor
15. Birthplace North Carolina

16 (a) Informant M. W. Tucker
(b) Address Kernersville, N. C.

17 (a) Removal (b) Date thereof 5/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Kernersville N C

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 19 1944 Huntington Mitchell Registrar
(Date rec'd by registrar)

VS 15]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1944 at 10:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 17, 1944 9:45 P. M.
(b) Where did injury occur? Hopkins Bus Rd, Back River
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Collision Auto & Street Car

23. Signature H. L. Wallenmeyer M.D.
Attending or Medical Examiner.
Date signed May 18, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17354 ~~(17356)~~ (17354) ~~(17353)~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 920 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B. Proctor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace UNKNOWN (Town, county, and state)

10. Usual Occupation Porter in

11. Industry or business Drug Store

FATHER
12. Name UNKNOWN.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace UNKNOWN.

16 (a) Informant
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-20-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemet.
Location

18 (a) Funeral director Mrs Katie Dillehay
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

MAY 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15/44, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions Scrotal Hernia.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Hugh W. B. McNally M.D. Medical Examiner.
Date signed 5/18/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17355 VG17355 [redacted] Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 W Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Cook Waters

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas Cook
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Elkridge Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Waters
FATHER 13. Birthplace Elkridge md

MOTHER 14. Maiden Name Lowenia Barnes
MOTHER 15. Birthplace Elkridge md

16 (a) Informant Ada Fordman
(b) Address 1612 McCulloh St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-20-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3227 W Lehmder St

19 MAY 19 1944 (Date rec'd by registrar) Huntington Woods N.Y.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/1944 at 1.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1944 to 5/18 1944 and that I last saw h alive on 3/13/1944

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days

Due to Syph. acute Pneumonitis — Duration 1 yr

Due to Nephritis — Duration 1 yr

Other Conditions Arterio Sclerosis — Duration 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Fordney M.D.
Address 719 N Carrollton Date signed 5/19/44

VS 3

G 17356 ✓ X G 17356

453631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret Altwater

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-76

8. AGE: Years 68 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Henry Bryan

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Maltry

15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Donnell Sta

18 (a) Funeral director John B. Connelly

(b) Address 718 Eastern Ave.

19 (a) Date received by registrar MAY 19 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 44, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 19 44 to May 16 19 44, and that I last saw her alive on May 16 19 44

Immediate cause of death: Cardiac insufficiency — Duration

Due to: Calcific aortic stenosis

Due to: Auricular fibrillation

Other Conditions: generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R Burningham M. D.

Address JHH Date signed 5/17

17357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 17357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 E. Federal St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Marshal Walstrum

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Male

5 Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martha A. Walstrum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/1861

8. AGE: Years 82 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Walstrum
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Amelia Schreck
15. Birthplace Washington

16 (a) Informant Lucille Wooten
(b) Address 1627 E. Federal St.

17 (a) Burial Private (Burial, cremation, or removal) (b) Date thereof May 20-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location 5712 O'Donnell

18 (a) Funeral director Elizabeth Hartle Funl.
(b) Address 115 E. West St.

19 Date received by Registrar MAY 20 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-1944 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30-1944 to 5-17-1944 and that I last saw ~~him~~ alive on 5-17-1944

Immediate cause of death Heart Block — Duration 17 days

Due to Arteriosclerotic cardio-renal disease — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Lybert M. D.

Address 730 N. Harford Ave. Date signed 5-18-44

17358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 17358

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Yolando ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion E. Libertini

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-6365

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A. Libertini

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1899

8. AGE: Years 45 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Giacomo Libertini

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Tamarino

15. Birthplace Italy

16 (a) Informant Mary A. Libertini (Wife)

(b) Address 3606 Yolanda Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1944 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Belair Rd. & Belt. Rd

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Harlem St.

19 MAY 20 1944 (Date received by registrar) (b) Registrar Huntington Millmore M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18- 1944, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebrae

Due to

Other Conditions Compression of Spinal Cord

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/3

(a) Date of injury 5-18- at 3 P. M.

(b) Where did injury occur Outside of 3606 Yolanda Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes

(d) Means of injury Fell, while putting up awnings.

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 5-19-44

453829 G 17359 BALTIMORE CITY HEALTH DEPARTMENT G 17359

CERTIFICATE OF DEATH 46 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State JAMAICA B.W.I. (b) County
(c) City or town KINGSTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 73-3rd St Mountain View Gardens (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Robert James Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes May (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-4-73

8. AGE: Years	Months	Days	If less than one day
71	0	15	hr. min.

9. Birthplace JAMAICA (Town, county, and state)
10. Usual Occupation Surveyor
11. Industry or business

FATHER
12. Name Robert John Miller
13. Birthplace JAMAICA

MOTHER
14. Maiden Name Martha J Chanders
15. Birthplace Ireland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Mt Washington, Md.

18 (a) Funeral director C. Harry Klein
(b) Address Lutherville, Md.

19 (a) (b) Huntington Williams Registrar

MAY 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 6 oz A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944, to May 19 1944, and that I last saw him alive on May 19 1944

Immediate cause of death	A.	Duration
Toxemia		
Due to Miles Operation		
Due to Carcinoma of Rectum		1 yr.
Other Conditions Terminal Pneumonia (Include pregnancy within 3 months of death)		

Date of operation 5-13-44
Major findings of operation: Carcinoma of Rectum Metastases
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. George Brunk
Address Johns Hopkins Hosp. Date signed 5-19-44

VS 150

C 17360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. C 17360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Av. & Dukeland
(c) Hospital or institution West Balt. Genl Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sandsdoune
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Second Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICIA LEE RIDGLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/3/43

8. AGE: Years | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation X

11. Industry or business

FATHER
12. Name Dolan C. Ridgely
13. Birthplace Md.

MOTHER
14. Maiden Name Patsy Hedrick
15. Birthplace W. Va.

16 (a) Informant Mr Dolan C. Ridgely
(b) Address Woodbine, Md.

17 (a) Burials (b) Date thereof May 21, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosemary Cemetery
Location Howard Co., Md.

18 (a) Funeral director C. Harry Klee
(b) Address Lyndenville, Md. Huntington

19 (a) (Date rec'd by Registrar) MAY 20 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1944, at 6.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944 to 5/18 1944, and that I last saw h.e.r. alive on 5/18 1944

Immediate cause of death — Duration

Marasmus

Due to Unresolved Pneumonia
Pancreatic Fibrosis (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/18/44

Major findings of operation: Unresolved Pneumonia

of autopsy: Pancreatic Fibrosis (?)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
B. Signature P. N. Friedman
Address West Balt. Genl Hosp. Date signed M. D. 5/18/44

17361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G 17361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Nef
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 678 Bradley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Larkins

3 (b) If veteran, name war W.W #1

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1892

8. AGE: Years 52 Months 5.5.0 Days 16 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Hoffman Bros

FATHER
12. Name Jerry Larkins
13. Birthplace Md.

MOTHER
14. Maiden Name Green
15. Birthplace St. Mary's Co.

16 (a) Informant Mary Larkins
(b) Address 678 Bradley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)

(c) Cemetery or crematory [illegible]
Location Baltimore Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 916 Bidwell Hill Ave

19 MAY 20 1944 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1944, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Paralysis, spinal

Due to Traumatic myelitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-21-44 at 17/1 12 01 A M.
(b) Where did injury occur? 569 Pine St
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
Means of injury Jaw off front train

23. Signature H. J. Walter Schreiber M.D. Medical Examiner.
Date signed May 18, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on certificate should be answered. If unknown, state the fact. Information should be furnished by person most likely to know the facts. Physicians: please write the causes of death clearly and legibly. Exact correct age is especially important.

G 17362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 17362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206½ McCulloch St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	15 hr. 10 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Premature baby
11. Industry or business

FATHER
12. Name Robert Lee Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillian Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Lillian Johnson
(b) Address 1206½ McCulloch St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Hohlt & Son
(b) Address 1700 Eastern Ave

MAY 20 1944 Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 945 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1944, to May 19 1944, and that I last saw him alive on May 19 1944

Immediate cause of death Atelectasis ?

Due to Prematurity

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leroy W Tilt M. D.
Address University Hosp. Date signed 5-19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 17363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17363

1318

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2327 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSALIE KUNKEL

3 (b) If veteran, name war: --
3 (c) Social Security Account No. 213-10-9812

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles H. Kunkel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/7/1875

8. AGE: Years 68 | Months 7 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk - Retired
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Joseph S. Caskey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Doyle
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Harry D. Caskey,
(b) Address 2327 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS MAY 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to May 18 1944, and that I last saw her alive on May 15 1944.

Immediate cause of death	Duration
Coronary Occlusion	3 days
Due to Myocarditis	1 year
Due to Chronic Nephritis	8 years
Other Conditions Rheumatoid Arthritis	10 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Samuel M. D.
Address 4509 Liberty Hts. Date signed May 18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 17364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton
(c) Hospital or Institution St Agnes Hosp 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4601 Wilkins Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Runge

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henrietta Runge

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 7 — 1865

8. AGE: Years 79 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Baltimore md
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm Runge
13. Birthplace md

MOTHER
14. Maiden Name Unknown
15. Birthplace md

16 (a) Informant Elmer L. Runge
(b) Address 4601 Wilkins Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore md

18 (a) Funeral director J. Chappell Sons
(b) Address 1300 Eutaw Place

19 (a) MAY 20 1944 (Date received by Registrar) Registrar

Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1944 at 12 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1944 to May 19 - 1944 and that I last saw him alive on May 19 1944

Immediate cause of death: Stercoral Intestinal Obstruction — Duration

Due to: Carcinoma of Bowel

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Kaffenberger M. D.

Address Date signed

G 17365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1258

G 17365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Rd + Dukeland St
(c) Hospital or institution: West Balt. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1205
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 Furrow St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ETHEL — OLIVER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward A. Oliver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 - 1904

8. AGE: Years 40 | Months 9 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard E. Duley
13. Birthplace Md

MOTHER
14. Maiden Name Anna Beare
15. Birthplace Md

16 (a) Informant Edwin A. Oliver
(b) Address 314 Furrow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. P. Hepplet & Son
(b) Address 157 W. Baltimore St.

19 (a) MAY 20 1944 (Date rec'd by registrar) Hampton Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1944 at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944 to 5/16 1944, and that I last saw h[illegible] alive on 5/16 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Auricular Fibrillation	
Due to	
Other Conditions: Mitral regalg Peripheral Edema (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. N. Friedman M. D.
Address West Balt Gnl Hosp Signed 5/16/44

G 17366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G 17366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5217 St. Charles ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5217 St. Charles ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cordelia M. Sears

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/9/1891

8. AGE: Years	Months	Days	If less than one day
52	10	9	hr. min.

9. Birthplace Washington D.C.
(town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John N Thorn
13. Birthplace England

MOTHER
14. Maiden Name Mary E. Griffith
15. Birthplace Virginia

16 (a) Informant John A. Sears
(b) Address 5217 St. Charles Ave.

17 (a) Burial (b) Date thereof May 22, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md.

18 (a) Funeral director F. B. Wippel & Son
(b) Address 1310 Eutaw Place

19 (a) (b)
(Date received by Registrar) Registrar

MAY 20 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18- 1944, at 10 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage, intra-ventricular

Due to trauma

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 5-14-44 at 1.50 A M.
(b) Where did injury occur? Annapolis Rd in Ferndale
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck with fist & knocked down

23. Signature Howard J. Waldeck M.D.
Medical Examiner.
Date signed 5-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 17367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

6 17367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Wilcox St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Wilcox St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Ebrman

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1880

8. AGE: Years 63 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Schrewsbury Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George H. Ebrman
13. Birthplace Schrewsbury Pa

MOTHER
14. Maiden Name Laura M. Baker
15. Birthplace Schrewsbury Pa

16 (a) Informant Mrs Harry E. Ebrman
(b) Address 1122 Wilcox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md

18 (a) Funeral director Edwin W. Cordell & Son
(b) Address 924 E. Eager St

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 20 1944

Huntington Williams M.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1944, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944, to May 19 1944, and that I last saw deceased alive on May 18 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 2 days

Due to Chronic Myocarditis — Duration: 6 yrs?

Due to Hypertension — Duration: 6 yrs?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Daneck M. D.
Address 2530 E. Baltimore St Date signed 5/19/44

12368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 12368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Mary Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Belle Schnepf

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles J. Schnepf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th. 1887

8. AGE: Years	Months	Days	If less than one day
57	0	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Charles J. Schnepf Jr.
(b) Address 4105 Mary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22,1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

MAY 20 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1944, to May 19 1944, and that I last saw her alive on May 19 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Congestive Heart Failure	
Due to Aortic Stenosis of Rheumatic Fever	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Aortic Stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Walkup M. D.
Address 1400 N. Caroline St. Date signed 5/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12869 — BALTIMORE CITY HEALTH DEPARTMENT — G 12869

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenway Apartments
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apts. 34th & Charles (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Kate E. Wilde Porter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife George H. Porter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1857

8. AGE: Years	Months	Days	If less than one day
86	4	20	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Isaac T. Wilde
13. Birthplace England

MOTHER
14. Maiden Name Catharine Paxon
15. Birthplace Pa.

16 (a) Informant George H. Porter
(b) Address Greenway Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery Lorraine
Location Windsor Mill Road, Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAY 20 1944 (Date received) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/44 19 ... at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1928 to 5/18 1944, and that I last saw her alive on 5/18 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	18 hrs
Due to Myocarditis	
Arterio-Sclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Crosby M.D.
Address 1403 Park Ave. Date signed 5/19/44

G 17370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157c

Registered No. G 17370

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 207
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days) 10 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Elgwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Grottendick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/44

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Balto., Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Grottendick
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret McGuire
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Grottendick
(b) Address 518 Elgwood St, Balto, 29. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Chas. F. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) MAY 20 1944 (Date received by Local Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1944, at 1 40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1944, to 5/20 1944, and that I last saw her alive on 5/20 1944

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Hydramnios	
Due to Anencephalic Monster	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. R. Boyle M. D.
Address Mercy Hosp. Date signed 5/20/44

173.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6 173.1 / 46 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give County)
(d) Street No. 1521 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col	Widowed

6 (b) Name of husband or wife Richard Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-18-1907

8. AGE: Years	Months	Days	If less than one day
37	-	-	hr. min.

9. Birthplace Knoxville - Tenn (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mc. Henry
13. Birthplace Ill.

MOTHER
14. Maiden Name Carrie Mc. Culloh
15. Birthplace Raleigh - N.C

16 (a) Informant Mrs. John Mc. Henry
(b) Address 1920 N. Market St - Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Estelle R. Williams
(b) Address 322 N. Paterson Ave.

MAY 20 1944 (b) Huntington Williams, M.D.
Date received (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18 1944 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1944 to 5/18 1944 and that I last saw her alive on 5/18 1944.

Immediate cause of death

Due to Carcinoma of Cervix
Due to Toxemia of Pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
3 Mos
14 Dys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher M.D.
Address 1 W Saratoga St Date signed 5/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G 17372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 765 George St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 765 George St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin T. Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race B | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annie Scott.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Elaine Bright

(b) Address 765 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location R.A. Co - Cedar Hill

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 327 N. Schroeder St.

19 (a) MAY 20 1944 Registrar's Office Huntington Williams M.D.

Local Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/44 19 67 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12/44 to 5/17/44 19 ; and that I last saw him alive on 5/17/44

Immediate cause of death Myocarditis Duration 4 days

Due to Arteriosclerosis

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Cecil Ellis M. D.

Address 704 Cathedral Date 5/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 17373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Catherine St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Catherine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam P. Dempsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lodie F. Dempsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1876

8. AGE: Years 67 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Real Estate Broker

11. Industry or business

FATHER — 12. Name James F. Dempsey
13. Birthplace Virginia

MOTHER — 14. Maiden Name Anna E. Brown
15. Birthplace Virginia

16 (a) Informant Mrs. Lodie F. Dempsey
(b) Address 114 S. Catherine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. D'VIPPERT & SON
(b) Address 1615 Eutaw Pl

19 (a) MAY 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5th 1943, to May 18 1944, and that I last saw him alive on May 18 1944

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Angina Pectoris & Coronary Inflammation — 5 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lyman Perry

Address 2202 W North Ave Date signed May 25 1944

VS 180

WEAVER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

17374 (×2)

Registered No. 17374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Boonesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 244 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert Weaver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Jane Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1918

8. AGE: Years 25 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)

10. Usual Occupation Railroad

11. Industry or business W. Md. Railroad

FATHER: 12. Name Douglas Weaver
13. Birthplace Va.

MOTHER: 14. Maiden Name Ruth Humbertie
15. Birthplace Md.

16 (a) Informant Mrs. Jane Weaver
(b) Address Box 244, Boonesboro, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 1944 (month) (day) (year)
(c) Cemetery or crematory Boonesboro Cemetery
Location Boonesboro Md

18 (a) Funeral director Wm J. Bast & Sons
(b) Address Boonesboro, Md

19 MAY 20 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944, to May 19 1944, and that I last saw h[illegible] alive on May 19 1944

Immediate cause of death: Pulmonary Edema due to
Postoperative Shock

Duration

Due to

Due to

Other Conditions: injection of Rt. upper lobe (Include pregnancy within three months of death)

Date of operation 5/18/44

Major findings of operation: Lac. Laceration of RML & RLL

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isabella Harrison M. D.
Address Church Home & Hospital Date signed 5/20/44

G 17375

453572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 84aG 17375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anita Blackmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	married

6 (b) Name of husband or wife Thomas Blackmon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-24-08

8. AGE: Years	Months	Days	If less than one day
36	-	24	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Walter Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Eva Gentry
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)

(c) Cemetery or crematory Lilburn
Location Northumberland Co. Va.

18 (a) Funeral director Mrs. E. H. Chase Funeral Home
(b) 1438 N. Gilmor St.

19 (a) [illegible] Clayton Williams, M.D. Registrar
(Date received by Registrar) MAY 22 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944 at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1944 to May 18 1944 and that I last saw h[illegible] alive on May 18 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumococcal meningitis Type 19	
Due to	
Other Conditions Mastoiditis + Middle ear infection (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Ginsberg M.D.
Address JHH Date signed 5-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the cause of death clearly and legibly.

~~6 1736~~ ✓ 6 1736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Bevans St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Bevans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hopkins

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1889

8. AGE: Years	Months	Days	If less than one day
55	2	25	hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

MOTHER / FATHER
12. Name Charles Robinson
13. Birthplace Md
14. Maiden Name Martha Bryant
15. Birthplace Md.

16 (a) Informant Charles Robinson (Brother)
(b) Address 707 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.
18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

MAY 21 1944
MAY 20 1944

19 Filed by registrar [illegible] Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/44 19 , at 4:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14- 1944 to 5-17- 1944, and that I last saw h[illegible] alive on 5-16- 1944

Immediate cause of death	Duration
Cerebral Intestinal Obstruction	
Due to ✓	
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Dayne M. D.
Address 1016 E. Preap St Date signed 5-20-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 17317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sears

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/13/1863

8. AGE: Years 81 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

MOTHER / FATHER

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Martha Sears (Wife)

(b) Address 1211 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l Pk.

Location Balto. County, Md.

18 (a) Undertaker or person acting as such Charles G. Cooper

(b) Address 512 N. Carrollton Ave

MAY 21 1944 Registrar

MAY 21 1944 (Registrar) (b) Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/44 19 , at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13/44 19 to 5/19/44 19 and that I last saw him alive on 5/19/44

Immediate cause of death: Lobar Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation?

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. F. Garbutt M. D.

Address 516 N. Carrollton Ave (Number) (Street)

5/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

61238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 12378

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Aisquith Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elem

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1883

8. AGE: Years 61 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name Godfrey Martin
13. Birthplace Va.

MOTHER — 14. Maiden Name Martha ?
15. Birthplace Va.

16 (a) Informant Elem Chase
(b) Address 1917 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/44 (month) (day) (year)
(c) Cemetery or crematory Forest Hill Cemetery
Location Hagerstown Md.

18 (a) Funeral director Fitz. Robt A. Alston Dft.
(b) Address 1129 N. Caroline St.

19 (a) Huddleston Williams, M.D. Registrar
(Date received by registrar)

MAY 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944 to May 18 1944 and that I last saw h[illegible] alive on May 17 1944

Immediate cause of death: Cardio Renal - Hypertension disease — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Hoon M. D.
Address 1617 N Caroline Date signed May 29 1944

454111 17379 ✓ X G 17379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

PRINT IN MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County St Mary's

(c) City or town Leonardtown (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marie Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-43

8. AGE: Years 1 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Young

15. Birthplace Md

MOTHER — 14. Maiden Name Marie Young

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-44 (month) (day) (year)

(c) Cemetery or crematory St Aloysius

Location Leonardtown Md

18 (a) Funeral director M. C. Mattingly & Son

(b) Address Leonardtown Md

19 (a) Date received by registrar 5-21-1944 Washington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 1301 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1944 to May 20 1944 and that I last saw h e alive on May 20 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Subdural Hematoma	4 wks?
Due to Trauma, time unknown 4 wks ago?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-18-44

Major findings of operation: No Subdural sack. Internal Hydrocephalus.

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence April 11 1944 M

(c) Where did injury occur? Leonardtown Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? No Fell out of bed

(e) Means of injury not known.

23. Signature Leonard Joel Young M. D.

Address Johns Hopkins Hosp Date signed 5-20-44

Approved: Robert Levy Graham M D May 24 1944

453755 G 17380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 17380 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs. 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8220 Northern Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Norway.

3 (a) FULL NAME Bjarne Olsen

3 (b) If veteran, name war: World War - 1 -
3 (c) Social Security Account No. 228-12-2331-A

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married (Single) M. Olsen

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Nov 13 1876

8. AGE: Years 48 | Months 6 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Salesman - Cons. Gro. Co.

11. Industry or business

FATHER
12. Name Cornelious Olsen
13. Birthplace Norway

MOTHER
14. Maiden Name Hannah
15. Birthplace Norway

16 (a) Informant Richter JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 1944 (month) (day) (year)
(c) Cemetery or crematory Rushtown Mem.
Location Portsmouth Ohio.

18 (a) Funeral director Robert L. & P. M. Walters
(b) Address Pratt & Stricker Sts.

19 (a) ... (Date received by registrar) (b) ... Registrar

MAY 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944 at 12 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944 to May 20 1944 and that I last saw h[illegible] alive on May 20 1944

Immediate cause of death	Duration
Uremia	
Due to malignant arteriolar nephrosclerosis	
Due to	
Other Conditions Hypertensive C-V disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen Conem
Address J H H Date signed 5-20 (M. D.)

G 17381

454171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57E

G 17381

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Daytona Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Cannon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Deane Rawlins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-19

8. AGE: Years 24 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Fla. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Robert W

13. Birthplace Fla.

MOTHER — 14. Maiden Name Lacy Jane Hornell

15. Birthplace Fla.

16 (a) Informant [illegible]

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)

(c) Cemetery or crematory Greenwood Cemetery

Location Daytona Beach, Fla.

18 (a) Funeral director John A Mitchell Sons

(b) Address 190 N Eutaw Place

(a) Date received 5-21-1944 (b) [illegible] Registrar (Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944 at 2 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944 to May 19 1944 and that I last saw h[illegible] alive on May 19 1944

Immediate cause of death	Duration
Hypertrophied tumor - pituitary body	
Due to Cerebral edema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/15/44

Major findings of operation: Hypertrophied tumor

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm W. Chambers

Address Johns Hopkins Hosp. Date signed 5/15/44

G 17382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G 12382 Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town South Orange (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond J. Baron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Newark N.J. (Town, county and state)

10. Usual Occupation Deck hand

11. Industry or business

FATHER
12. Name Louis Baron
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Filmore
15. Birthplace Pittsburg, Pa.

16 (a) Informant Mrs. R. Baron
(b) Address South Orange, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)

(c) Cemetery or crematory
Location Newark N.J.

18 (a) Funeral director Leo H. Lebkuecher
(b) Address 1201-03 N. Patterson Park Ave. Baltimore, Md.

MAY 21 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944 at 9 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found drowned

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/17/44 at M.
(b) Where did injury occur Pier #6 Long Wharf East Side
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work?
(d) Means of injury Drowning

23. Signature Robert C. Fraser M.D.
Medical Examiner.
Date signed May 20 1944

PLEASE WRITE PLAINLY, with pen and ink. Report cause of death clearly and legibly. Do not abbreviate. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C 17353 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Knight

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex ~~Male~~ Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~Cornelius~~ Sherman Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20th 1865

8. AGE: Years	Months	Days	If less than one day
78	4	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William H. Leonard
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane (Unknown)
15. Birthplace Md.

16 (a) Informant C. Leonard Wright
(b) Address 723 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] Huntington Williams, M.D. Registrar

MAY 21 1944 Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1944, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944, to May 18 1944, and that I last saw h[illegible] alive on May 18 1944

Immediate cause of death: Sudden cardiac failure — Duration 1 Hours
Due to: Arterio sclerotic heart disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. Gibson Porter
Address 4822 Roland Ave Date signed 5/19/44

G 17384 ✓ G 17384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Radnor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Ruth.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-16-4699

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26. 1881

8. AGE: Years 62 | Months 7 | Days 18 | If less than one day 22 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name David Ruth
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Hess
15. Birthplace Baltimore Md

16 (a) Informant Mildred Cook
(b) Address 503 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 2412 Pennsylvania Ave

19 (a) (b) Registrar
(Date rec'd by registrar) MAY 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/1944, at 8.35 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Harry W. B. McNally M.D. Medical Examiner.
Date signed 5/19/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

454382 G 17385 BALTIMORE CITY HEALTH DEPARTMENT G 17385

CERTIFICATE OF DEATH 157E

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Lansing Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Thomas Richard Taylor

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-6-44

8. AGE: Years ..... Months 7 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER 12. Name William Taylor
13. Birthplace Md

MOTHER 14. Maiden Name Lena Pruy
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory [redacted] Mt. Olivet Md.
Location .....

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
(c) (Date received) MAY 21 1944 (By) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944, at 8.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944, to May 18 1944, and that I last saw h.i.m alive on May 18 1944.

	Duration
Immediate cause of death: respiratory failure	
Due to: pneumonia	3 days
Due to:	
Other Conditions: congenital heart disease (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp Date signed 5-19-44

G 17386 ✓ G 17386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACESED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 W. 26th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John B. Rennie

3 (b) If veteran, name war WWI #1
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 13, 1894

8. AGE: Years 49 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Roofer

11. Industry or business

FATHER 12. Name Thomas S. Rennie
13. Birthplace Maryland

MOTHER 14. Maiden Name Ann Boone
15. Birthplace Maryland

16 (a) Informant Joseph Rennie
(b) Address 1409 N 24th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros Co
(b) Address 127 E Lexington

19 (a) (b) Registrar

MAY 21 1944 (Date filed with registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1944 at 3½ A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-18 1944 to 5-20 1944. and that I last saw h[illegible] alive on 5-17 1944.

Immediate cause of death C-V + ailure — Duration

Due to Cirrhosis of Liver

Due to Malignancy of Liver.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Von Dell III M. D.
Address Union Memorial Hosp Date signed 5-20-44

G 17387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17387 Registered No. 13/a

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 Webb Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Morgan Jr

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Stella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26. 1881

8. AGE: Years 63 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Truck Loader Retired
11. Industry or business

FATHER
12. Name Charles W Morgan
13. Birthplace Md

MOTHER
14. Maiden Name Harriett Hatton
15. Birthplace Md

16 (a) Informant Mrs Stella Morgan
(b) Address 933 Webb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Wilhelm York Inc
(b) Address 1217 E Lond St

19 (a) 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 to 5/20 1944, and that I last saw h[illegible] alive on 5/19 1944

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Renal Disease	2
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bloom M. D.
Address 806 E. Eutaw Date signed 5/22/44

G 17388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G 17388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Mura St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Nappel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-36

8. AGE: Years 8 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Henry Nappel
13. Birthplace Md

MOTHER
14. Maiden Name Anna Mackley
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar) MAY 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to May 19 1944 and that I last saw her alive on May 19 1944

Immediate cause of death Hydrocephalus
? Remnant brain tumor — Duration ?

Due to Post operative block

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ?

Major findings of operation: 3rd Ventricle tumor

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugo V. Rizzoli M. D.
Address Johns Hopkins Hosp. Date signed 5-19-44

G 17389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G 17389 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Sharp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Reily
13. Birthplace

MOTHER 14. Maiden Name Anna Bryan
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 917 Greenmount Ave

19 (a) (Date rec'd by registrar) (b)

MAY 21 1944

MEDICAL CERTIFICATION 8. a. m.

20. DATE OF DEATH May 20 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944, to May 20 1944, and that I last saw h[illegible] alive on May 19 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteio Sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 5/20/44

G 17390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17390 1639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Lucille Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Cohen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 34 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation PHARMACIST

11. Industry or business

FATHER 12. Name Abraham Cohen

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Hinda —

MOTHER 15. Birthplace Russia

16 (a) Informant Abraham Cohen

(b) Address 3500 Lucille Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-44 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cemetary

Location Washington Blvd

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore St.

19 (a) MAY 1 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19- 1944, at 8:50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Sodium Cyanide Poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-19- at Between 7:55 + 8:50 A M.

(b) Where did injury occur? Sinai Hospital

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes

(d) Means of injury Taken by mouth

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed 5-19-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17091

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts.
(c) Hospital or institution: West Balt. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE BATALION

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Harry Batalion

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benj. Kath
13. Birthplace Poland

MOTHER 14. Maiden Name Kash-
15. Birthplace Poland

16 (a) Informant Mrs. A. Irvin Batalion
(b) Address 410 Wiley st. Fairmount, W. Va.

17 (a) Burial (Burial, cremation, or removal), (b) Date thereof 5-21-44 (month) (day) (year)

(c) Cemetery or crematory Mucko Kodash Cem.
Location Hebrew Stevens Run

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) 1 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19 1944, at 2 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944 to 5/19 1944, and that I last saw h[illegible] alive on 5/19 1944

Immediate cause of death	Duration
DIABETIC COMA	
Due to Diabetes Mellitus	
Due to	
Other Conditions Pulmonary Congestion (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. N. Friedman M.D.
Address West Bell Genl Hosp signed 5/19/44

G 17392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17392 / 132

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balti
(c) City or town Balti (If outside city or town limits: write RURAL and give town)
(d) Street No. 1616 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Tompakov

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Miriam Tompakov

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Hyman L. Lampalear
13. Birthplace Russia

MOTHER
14. Maiden Name Rivi Leah
15. Birthplace Russia

16 (a) Informant Morris Lampalear
(b) Address 1616 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-44 (month) (day) (year)
(c) Cemetery or crematory Chevra Hasath Anoshi
Location Belair Rd & Erdman Ave

18 (a) Funeral director Jacob Levin
(b) Address 1429 E. Baltimore St

19 (a) MAY 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21-44 19 , at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1943, to 5/20 1944 and that I last saw him alive on 5/20 1944

Immediate cause of death Ch Pulmonary Th

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M.D.
Address 733 Argyle St Date signed 5/24/44

G 17393 G 17393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S Chapelgate La
(c) Hospital or institution: Pine Crest Sanitorium
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Garrett
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne McCorle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1876

8. AGE: Years 67 | Months 9 10 | Days 9 | If less than one day hr. min.

9. Birthplace Ft. Lee, (Town, county and state)

10. Usual Occupation School Teacher

11. Industry or business Retired

FATHER
12. Name Michael McCorle
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Boyle
15. Birthplace Ireland

16 (a) Informant Wm McCorle
(b) Address 337 Austen N.Y.

17 (a) Burial (b) Date thereof 5-22-44
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Carlton Hill
Location Baltimore Md

18 (a) Funeral director Geo. A. Fuchs
(b) Address Fulton & Fayette

19 (a) MAY 21 1944 (b) Washington Millicent Reg.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19 1944 at 1304

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to 5/19 1944 and that I last saw her alive on 5/19 1944.

Immediate cause of death Myocardial infarct
Due to Arteriosclerosis

Due to

Other Conditions Senile Dementia
Paralysis agitans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 Wks
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dorothy P. Magee M.D.
Address 3326 Fulton Ave Date signed 5/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G 17394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Andre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Andre St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara H. Lang

3 (b) If veteran, name war: c
3 (c) Social Security Account No.: c

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Adam Lang
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 26th 1884
8. AGE: Years 60 | Months 1 | Days 23 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name August Voelkel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Adam Lang
(b) Address 1400 Andre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, '44 (month, day, year)
(c) Cemetery or crematory London Park
Location Frederick Rd

18 (a) Funeral director Chas. F. Dill
(b) Address 1521 E. Fort Ave
(c) (Signature of undertaker) Chas. F. Dill

MAY 21 1944
(Date received by Registrar) Christopher Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944, at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1944, to May 18 1944, and that I last saw her alive on May 17 1944.

Immediate cause of death	Duration
Carcinoma Pancreas	2 days
Ascites Cirrhosis of Liver	2 mo
Due to Carcinoma cervix uteri	6 weeks
Due to Diabetes Mellitus	3 mo
Other Conditions Chr Pancreatitis Hydrothorax Fibroid Tumor Uterus	3 mo
(Include pregnancy within 3 months of death)	27 yrs

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Esa Stevens M.D.
Address 2878 Hereford Rd Date signed May 19 1944

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 17395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3534 E. FAIRMOUNT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3534 E. FAIRMOUNT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEO C. LENGSFELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNA M. LENGSFELD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 26 1902

8. AGE: Years	Months	Days	If less than one day
41	9	23	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NIGHT WATCHMAN
11. Industry or business KIMBELL & TYLER CO.

FATHER
12. Name FREDERICK LANGSFELD
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARGARET KREMPEL
15. Birthplace BALTO. MD.

16 (a) Informant ANNA M. LANGSFELD (WIFE)
(b) Address 3534 E. FAIRMOUNT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 24/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) 5/24/44 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 116

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH MAY 19 1944 at 10½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1944 to 5/19 1944.
and that I last saw h. alive on 5/19/1944.

Immediate cause of death: Acute Dilatation of Heart — Duration: Instantaneous
Due to
Due to
Other Conditions Angina Pectoris
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hugh L. Lieder
Address 3323 E. Balto St. Date signed 5/20/44

Approved: Robert Lee Grattan M.D. May 21 1944

G 17396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17396 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2920 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary K. Freet

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: HOWARD M. FREET

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): UNKNOWN

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: JOHANSON PETRAKIS
13. Birthplace: W.VA.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: W.VA.

16 (a) Informant: HOWARD M. FREET (HUS.)
(b) Address: 2920 ELLIOTT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 23/44 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE. EXT.

18 (a) Funeral director: Lilly and Geiler Inc
(b) Address: 403 S. WOLFE ST.

19 (a) 5-19-44 Huntington Williams M.D. (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 5 30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to Hypertensive Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gratan M.D. Medical Examiner.
Date signed May 20 1944

FILING INSTRUCTIONS: Fill out completely and correctly. Every item must be answered. If unknown, write UNKNOWN. Physicians: please write the causes of death clearly and legibly. Exact correct age is especially important.

Spec.—2-20-25—L. F. S.—500 Blks.

G 17397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

√83B G 17397

1—PLACE OF DEATH MCKENNA MEMORIAL CLINIC

CITY OF BALTIMORE: (No. STONEY LANE BALTO. MD. ST., 26 WARD) 11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MICHAEL M. ELBERTH

(a) RESIDENCE NO. 702 S. CLINTON ST., WARD

(Usual place of abode) LIFE (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
MALE	WHITE	WIDOWER

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ELIZABETH ELBERTH

6 DATE OF BIRTH (month, day, and year) 12/9/ 80

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
63	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work DRY GOODS & NOTIONS

(b) General nature of industry, business, or establishment in which employed (or employer) OWNER

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTO. MD

PARENTS

10 NAME OF FATHER AUGUAT ELBERTH

11 BIRTHPLACE OF FATHER (city) GERMANY (State or country)

12 MAIDEN NAME OF MOTHER ANNIE RICHARD

13 BIRTHPLACE OF MOTHER (City) BALTO. (State or country)

14 Informant MRS. SIMMS (DAUGHTER)

(Address) 505 OLD ORCHARD RD

MAY 21 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19-1944

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1944, to May 19, 1944, that I last saw h. alive on May 19, 1944, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs 2 mos 7 ds.

CONTRIBUTORY (Secondary) Hypertension - arteriosclerosis

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John H. Travelpiece M. D.

, 19 (Address) 1035 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL May 22 1944

20 UNDERTAKER Lilly and Zeiler, INC

ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

G 17358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17358

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 E 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 E 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Lawg Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years 68 | Months — | Days — | If less than one day hr. min.

9. Birthplace Warren Balto Co
(Town, county and state)

10. Usual Occupation Clerk

11. Industry or business Food Gov

FATHER
12. Name Williams Burns
13. Birthplace Balto Co

MOTHER
14. Maiden Name Hewitt Freeland
15. Birthplace Balto Co

16 (a) Informant Mrs Margaret Burns
(b) Address 715 E. 23rd St

17 (a) Burial — (b) Date thereof 5-22-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loyola Cemetery
Location — Balto Co. Md

18 (a) Funeral director Mary W. Wiedefeld
(b) Address 501 E 22nd St

19 (a) (b)
Received by registrar MAY 21 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19/1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to May 19 1944, and that I last saw him alive on 5/19/1944

Immediate cause of death: (a) Coronary Thrombosis — Duration 8 mos
Coronary Sclerosis — 4 mos
(b) Myocardosis — 6 mos
Due to: Arteriosclerosis
Due to:
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Thomas J Burke
Address 532 E 22nd St Date signed M/D 5/20/44

G 17359 ✓ G 17359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2565 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Hucke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace L. (nee Spies)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1884

8. AGE: Years 59 | Months 5 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER — 12. Name Christopher Hucke
13. Birthplace Germany

MOTHER — 14. Maiden Name Mary Blessing
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Grace L. Hucke,
(b) Address 2565 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/44. (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry H. Hubbe
(b) Address 4101 Edmondson Ave.

19 (a) Date registered MAY 24 1944 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18/44. 19 .745 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 2 1944, to May 18 1944, and that I last saw him alive on May 18 1944.

Immediate cause of death: Cerebral Embolism — Duration: Hours, 1 Months
Due to: Carcinoma of Larynx — Duration: Hours, 2 Months
Due to: — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Moore M. D.
Address 16 Bank Street Date signed May 24 44

17400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 17400
Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette 920 Collington
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Pelham Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mildred Hresko 32081

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife John J. Hresko
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1923

8. AGE: Years	Months	Days	If less than one day
20	11	3	hr. min.

9. Birthplace Anapolis, Md. (City, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER
12. Name Frank Skubal
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Sterba
15. Birthplace Czechoslovakia

16 (a) Informant husband
(b) Address 3107 Pelham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison St.

MAY 21 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18-44 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17-44 19..., to 5-18-44 19..., and that I last saw her alive on 5-18-44 19...

Immediate cause of death	Duration
Circulatory Collapse	
Due to Acute dilatation of heart	
Due to Myocardial weakening due to toxemia when a child	over

Other Conditions Still Born Pregnancy
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Clyde Webster M.D.
Address Franklin Sq. Hosp. Date signed 5/21/44

G 17401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G 17401

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days) G.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1944 N. Patterson Park (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Ida Gorczwicz (Krause)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fem

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-19-1900

8. AGE: Years	Months	Days	If less than one day
43 44	11	29	hr. min.

9. Birthplace Balto Md (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Stephen Lorek
13. Birthplace Poland

MOTHER
14. Maiden Name Minnie Amelung
15. Birthplace Balto Md

16 (a) Informant Mrs. Helen Wolfe
(b) Address 1836 Gough Sta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd

18 (a) Funeral director John B. Connelly
(b) Address 4118 Eastern ave.

19 MAY 22 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1944, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1944 to 5/18 1944 and that I last saw him alive on 5/18 1944

Immediate cause of death	Duration
Pulmonary congestion	
Due to Myocardial insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm. cong., emphysema, arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Abrams, M.D.
Address Sinai Hosp Date signed 5/18/44

VE 150

G 17402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

17402 Registered No.

PRESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 328 Lorraine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatz John Vogl

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna Gabler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1855

8. AGE: Years 89 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation: Retired Machinist, 20yrs
11. Industry or business

FATHER
12. Name: ? Vogl
13. Birthplace: Austria

MOTHER
14. Maiden Name: Unknpwn
15. Birthplace: "

16 (a) Informant: Paul Vogl (Son)
(b) Address: 3320 Bayonne Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Ave. & Broadway

19 (a) Filed MAY 22 1944 (b) Signature of Registrar: Walter Williams M.D.

VS 150

MEDICAL CERTIFICATION

P. M

20. DATE OF DEATH May 18 1944, at 3:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11/44 19 to 5/18/44, and that I last saw h[illegible] alive on 5/18/44

Immediate cause of death	Respiratory Failure	
Due to	Cardiac failure	
Due to	Arteriosclerotic cardio vascular disease	
Other Conditions		

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isadore Shorofsky M.D.
Address 601 N. Monroe St Date signed 5/20/44

G 17403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 17403 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bogan McKay

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-3276

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1900

8. AGE: Years 44 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Hamlet, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Virgil McKay
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace N. C.

16 (a) Informant Christiana Bright
(b) Address RFD 2 Box 15 Hamlet N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)

(c) Cemetery or crematory
Location Hamlet, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Brantley Ave

MAY 22 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 44, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 19 44, to May 19 19 44, and that I last saw her alive on May 19 19 44.

Immediate cause of death Myocarditis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Snyder M. D.
Address 1634 E. Baltimore Date signed 5/20/44

G 17404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 17404 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvester Pulliston (Puleston)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Ca | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/1865

8. AGE: Years 79 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation Waiterman

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Natalie Ruth

(b) Address 1616 Druid Hill Ave

17 (a) Burial (b) Date thereof May 23-44
(Burial, cremation, or removal) (Month) (Day) (year)

(c) Cemetery or crematory Mt Calvary

Location A.A. Co., Md.

18 (a) Funeral director James A. Hayes

(b) Address 1142 W. Lafayette St.

19 (a) (b) Huntington Williams, M.D.
Registrar

MAY 22 1944
VS 18

Approved: Robert Lee Graham M.D. May 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19/1944, at 1 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27/1944, to 5/19/1944 and that I last saw him alive on 5/19/1944.

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions Fractured Left Femur (neck)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 1442
(b) Date of occurrence 3/25/44 at M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Fell in Kitchen
23. Signature Burnal Harris M. D.
Address Provident Hosp. Date signed 5/19/44

G 17405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 17405
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William A. Albaugh

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Mary B. Albaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1869

8. AGE: Years	Months	Days	If less than one day
74	8	29	hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Concert Business

11. Industry or business: Self

FATHER
12. Name: William A. Albaugh
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown Snyder
15. Birthplace: Md.

16 (a) Informant: Mrs. David C. Gibson
(b) Address: 106 W. Melrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 22 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 10 25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 20 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 17406 BALTIMORE CITY HEALTH DEPARTMENT G 17406
CERTIFICATE OF DEATH 134a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 E. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LENA TOWNSEND DEESE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife Amos Deese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1901

8. AGE: Years	Months	Days	If less than one day
42	9	29	hr. min.

9. Birthplace Lumberton, N. C. (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business Union Memorial Hosp.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Doccia Townsend
15. Birthplace N. C.

16 (a) Informant Mrs. J. E. Parker
(b) Address 606 N. Poplar St., Charlotte, N. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/22/44 (month) (day) (year)
(c) Cemetery or crematory
Location Charlotte, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) MAY 22 1944 Huntington, Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1944, at 4:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13th 1944, to 5/20th 1944, and that I last saw h[illegible] alive on 5/20th 1944

Immediate cause of death	Duration
Kidney Hemorrhage	
Due to Sloughing of Granulomatous	
Due to Removal of Gauze	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. J. Tickner M. D.
Address 100 E. Lafayette Date signed

C 17407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C 17407 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Parkmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose H. Henss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Henss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11. 1868

8. AGE: Years 75. Months 9 Days 11/10 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Adolph Mayer Frank Schlegel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dora Elizabeth Schmertz
15. Birthplace Baltimore

16 (a) Informant Henry Henss
(b) Address 4408 Parkmont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24. (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Uhlrich Funeral Home
(b) Address 2004 E. Orleans

MAY 22 1944 (Date filed by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1944, at 2.55 M

21. I certify that I took charge of the remains described above, held an Inquest-Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intussusception C.V. disease
Due to Congestive Cardiac Decompensation
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester S. Lehmann M.D. Medical Examiner.
Date signed 5/21/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17408
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Cold Spring Nursery
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A A Co
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Ridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Brehm

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Fred Brehm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13-1905

8. AGE: Years 39 | Months — | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Adolph Meyer
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Fred Brehm
(b) Address 121 Ridge Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2754 E Monument

19 (a) MAY 22 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to May 19 1944, and that I last saw her alive on May 19, 1944.

Immediate cause of death Multiple Sclerosis — Duration 2 yrs.
Due to
Due to
Other Conditions Bronchopneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel A Wolfe
Address 1321 E. North Ave Date signed 5-20-44

G 17409

AB-88168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 17409

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos- 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1334 Aisquith St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

99

3 (a) FULL NAME Charles Wainwright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9- 1900

8. AGE: Years	Months	Days	If less than one day
43	10	7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/44 (month) (day) (year)

(c) Cemetery or crematory Laurel Memorial Park
Location Cerman Hill Road

18 (a) Funeral director Neal Taylor Sons
(b) Address 131 E. Biddle St.

19 (a) (b) (Registrar)

Registrar

MAY 22 1944

Hampton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944, at 3.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1943, to 5-16 1944, and that I last saw h[illegible] alive on 5-16 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul Hattrup M.D.

Address B. C. H. Date signed 5/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17410
Registered No.

AB-88025

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1254 Woodbourne Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellis H. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 579-12-8866

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Caroline Currie (nee Ennenberg) (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 9-1869

8. AGE: Years	Months	Days	If less than one day
75	-	10	..... hr. ..... min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation department guard
11. Industry or business U.S. Govern.

FATHER
12. Name Zachariah Wilson
13. Birthplace ? Indiana

MOTHER
14. Maiden Name Emma ? Townsend
15. Birthplace ? Indiana

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)
(c) Cemetery or crematory N. Cathedral
Location Old Frederick Rd.

18 (a) Funeral director M. W. E. Upperman Sons
(b) Address Lan. Lard + Hanover Sts.

19 (a) ..... (b) .....
Registrar

MAY 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1944, to 5-19 1944, and that I last saw h[illegible] alive on 5-19 1944.

Immediate cause of death	Duration
Hemorrhagic Enteritis	?
Uremia	?
Due to Mesenteric Thrombosis?	?
Hypertensive Cardio Vascular Disease	?
Due to Gen. Arteriosclerosis	?

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Hebb M. D.
Address Balto City Hosp Date signed 5-20-44

G 17411

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17411 Registered No.

CERTIFICATE OF DEATH 13 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E. Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Tully Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1916

8. AGE: Years 27 | Months 9 | Days 8 | If less than one day, hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Drafting

11. Industry or business

FATHER — 12. Name Mr. Howard Burns

13. Birthplace Washington D.C.

MOTHER — 14. Maiden Name Eugenia Tully

15. Birthplace Maryland

16 (a) Informant Catherine F. Tully

(b) Address 324 Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)

(c) Cemetery or crematory St. Peters

Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS

(b) Address 1827 W. North Ave.

MAY 22 1944 Hampton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944 at 9 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1944 to 5-21 1944 and that I last saw him alive on 5-21 1944

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to Uremia

Due to Chronic Glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Brumgardt Jr.

Address 332 E. University Pkwy Date signed 5/21/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

G 17412 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 N. Mechen St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 208 N. Mechen St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Roberta R. Green

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1888

8. AGE: Years 55 | Months -6 | Days -14 | If less than one day hr. min.

9. Birthplace Petersburg, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Gillien
13. Birthplace Petersburg, Va

MOTHER
14. Maiden Name Lucy Jones
15. Birthplace Petersburg, Va

16 (a) Informant Hattie Lynch
(b) Address 208 N. Mechen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) [illegible] Williams, M.D. Registrar

MAY 22 1944

VS-180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19- 1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3- 1944, to 5-19- 1944, and that I last saw her alive on 5-18- 1944

Immediate cause of death: Carcinoma of Uterus — Duration: 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. W. Coogan M. D.

Address 611 N. Carolina Date signed 5-22-44

G 17413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17413

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 Shields St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Shields St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Belle A. Barker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elias

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1873

8. AGE: Years 71 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Harry Sackett
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Harold L. Barker Jr.
(b) Address 1535 Shields St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore Md.

18 (a) Funeral director Mrs. George W. Hyatt
(b) Address 1631 Druid Hill Ave.

19 (a) MAY 22 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1945 to 5/19 1945 and that I last saw h[illegible] alive on 5/19 1945.

Immediate cause of death: Cardio-Renal Failure — Duration 1 Day
Due to — 1 Mo
Due to — 1 Day
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature B. F. Hafaka M. D.
Address 1 W N Rd Ave Date signed 5/22/45

VS 150

G 17414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

G 17414 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 718 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Jane McKenna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Wh

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 25 1890

8. AGE: Years 53 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Claude Ridell
13. Birthplace Richmond, Va

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Baltimore

16 (a) Informant Mrs Trench
(b) Address 720 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 24 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director D. L. Carrington
(b) Address 21 N 25 St

19 (a) MAY 22 1944 (Date rec'd)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1944 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1939 to 5-20 1944 and that I last saw h[er] alive on 5-20 1944

Immediate cause of death Acute Cardiac Failure — Duration 10a

Due to Rheumatic Cardio-Vascular Disease — 54y

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L Lawrence M. D.

Address 719 Washington Blvd signed 5/20/44

C 17415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17415 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write the name of the county in which the place is located)
(d) Street No. 713 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard L. Jubb

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 218-14-7681

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillian [illegible] Jubb

6 (c) If alive, give age 1899 years

7. Birth date of deceased (mo., day, yr.) June 7 1899

8. AGE: Years 44 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Ship fitter.

11. Industry or business

FATHER 12. Name Thomas Jubb
13. Birthplace Md.

MOTHER 14. Maiden Name Ellen Hanshaw
15. Birthplace Md.

16 (a) Informant Lillian Jubb
(b) Address 1406 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem
Location Loyola Blvd.

18 (a) Funeral director John J. Mullen & Sons
(b) Address 2334 Jefferson St

MAY 22 1944 (Date rec'd by registrar) [illegible] M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/44 19 , at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1944 to 5/18 1944 and that I last saw him alive on 4-18 1944

Immediate cause of death Pulmonary edema

Due to Bronchogenic CA c metastasis to lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchogenic CA c lung metastasis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick Weisel M. D.

Address Brain Hosp. Date signed

H 5-2936

G 17418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47D

G 17416
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) George Holcomb this Richard all

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1510 Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME → George Hawkins

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Beatrice Hawkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14 1893

8. AGE: Years 51 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer - Contractor

11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Sallie Hawkins
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Lee D. Kelson
(b) Address 1303 Pennsylvania Ave

(b) MAY 22 1944 (Date received by Registrar) Kathryn Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944 at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1944 to May 20 1944 and that I last saw him alive on May 20 1944

Immediate cause of death: Respiratory Failure — Duration

Due to Undifferentiated CA of lung & metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Bonem M. D.
Address JHH Date signed 5/20

G 17417 Transcripts

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17417
CERTIFICATE OF DEATH 830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5611 Winner Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Winner Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence A. Wiles

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-8473

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martha Wiles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1871

8. AGE: Years 73 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto Transit Co Foreman

FATHER 12. Name Levi D. Wiles

13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Anna K. King

15. Birthplace Frederick Co Md

16 (a) Informant Mrs. Jay Morris

(b) Address 5611 Winner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)

(c) Cemetery or crematory Pella Cemetery

Location Pella, Maryland

18 (a) Funeral director Loring Bryson

(b) 5 W. Lafayette Ave

MAY 22 1944 (Date rec'd by registrar) (c) Thos. Dayton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1944. at 9:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1944. to May 19, 1944. and that I last saw him alive on May 17, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 19 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Martin M. D.

Address Randallstown Date signed 5/21/44

C 17418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C 17418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 Presstman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Presstman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Samuel L. Bloom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Louis Sherman
13. Birthplace Russia

MOTHER
14. Maiden Name Bala
15. Birthplace Russia

16 (a) Informant Mrs. Blaine
(b) Address 2206 Prestman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Beth Jacob
Location Whitehall Mill Road

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St.

19 MAY 22 1944 (b) Washington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1944, at 10 15 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Degenerative Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Theodore B. Michaelis M.D.
Medical Examiner.
Date signed 5/22/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Feb 17419

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17419
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 E. Fairmount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 E Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAVID ROMONOFSKY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

MOTHER / FATHER

12. Name Harry Romonofsky

13. Birthplace Russia

14. Maiden Name Hannah

15. Birthplace Russia.

16 (a) Informant Mary Romonofsky

(b) Address 2204 E. Fairmount Ave

17 (a) Burial Beechwood (Burial, cremation, or removal) (b) Date thereof V-22-44 (month) (day) (year)

(c) Cemetery or crematory Beechwood

Location Old Pike & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH V-21-44 19 .. at ✓ P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 19 44 to May 20 19 44, and that I last saw h[illegible] alive on May 20 19 44.

Immediate cause of death Pulmonary Tuberculosis — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Snyder M. D.

Address 163 E. Baltimore Date signed 5/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 17420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17420 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE STRAUSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Herman Strauss
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah
15. Birthplace Germany

16 (a) Informant Bertha Strauss
(b) Address 2411 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1432 E. Baltimore St

19 (a) (b) (Date received by registrar) Registrar

MAY 22 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1944, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-18 1944 to 5-20 1944, and that I last saw h.e.r. alive on 5-20 1944.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	
Due to Chronic Glomerulo-nephritis	
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. S. Aurich M. D.
Address Sinai Hosp Date signed 5-20-44

G 1742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17421 ✓

Registered No. 32

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 249 East St

(c) Hospital or institution 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 249 East St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If so, name country

3 (a) FULL NAME Samuel Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: 65 Years | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and State)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Hyman

13. Birthplace Russia

14. Maiden Name Slotta

15. Birthplace Russia

16 (a) Informant Dora Hoffman

(b) Address 249 East St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Po Conn & St

18 (a) Funeral director Jack Levin Inc

(b) Address 439 E Balto St

19 MAY 22 1944 (Date rec'd by registrar) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 1944 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936, to May 21 1944, and that I last saw him alive on May 21, 1944

Immediate cause of death Coronary Thrombosis — Duration 1/2 hour

Due to Coronary Sclerosis — 5 years

Due to

Other Conditions Chronic Fibroid Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thurlow Cooper M. D.

Address 2107 Park Ave Date signed 5/24/44

VS 180

G 1742 ✓ G 17422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 Reynolds St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Reynolds (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Augusta A Kemme

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25-1863

8. AGE: Years 80 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Fredrick Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Claus
15. Birthplace Germany

16 (a) Informant Christian A Kemme
(b) Address 400 Croydon Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 23-44 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location

18 (a) Funeral director George Schilling's Son
(b) Address 3624 Gwynnmount Ave

19 (a) (b)

VS 10 MAY 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20- 1944, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1944 to May 20 1944 and that I last saw her alive on May 20 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to: Diabetes Mellitus Indefinite

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Hanover Date signed 5/24/1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~B 17423~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106C

G 17423

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Tampa (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Morgan St, Tampa, Fla (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shayla Ann Hodges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 3½ | Days | If less than one day hr. min.

9. Birthplace Fla. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James H Hodges
13. Birthplace Fla

MOTHER
14. Maiden Name Mary Mann
15. Birthplace Fla

16 (a) Informant Mary Mann
(b) Address 16 Penna Ave, Tampa Fla

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 22, 1944 (month) (day) (year)

(c) Cemetery or crematory Seashole Funeral Home
Location Jacksonville, Florida

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland

19 (a) Registrar

MAY 22 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1944, to 5/20 1944, and that I last saw her alive on 5/20 1944

Immediate cause of death Respiratory failure & massive collapse of rt lung, d

Due to Pneumo. Lt lung, & laryngo

Due to Tracheo bronchitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Bronchoscopy 5/17/44

Major findings of operation: Mucus in rt bronchiole

of autopsy:

Duration
2½ mo
36-48 hr

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M June Daley M. D.
Address Date signed

G 17424 ✓ G 17424

G 17424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Marshall Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country —

3 (a) FULL NAME Helen BURHAM. (Burnham)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband ~~or wife~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Pikesville, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Raymond Burnham
(b) Address 1603 Marshall Ave, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Sater's Cemetery
Location Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 22 1944 Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944 at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1944 to 5/20 1944, and that I last saw h alive on 5/20 1944.

Immediate cause of death Terminal bronchopneumonia.
Due to CNS Lues.
Due to Lesion of the atrophy.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. MacDonald M. D.
Address 1212 Light St Date signed 5-20-44

G 17425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 17425 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Harlem Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosetta V. Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wm. H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1882

8. AGE: Years 62 | Months - | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Palestine S. Henry
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Margaret Thompson
15. Birthplace Cambridge Md

16 (a) Informant Irene V. Frazier (D)
(b) Address 1017 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Charles S. Cooper
(b) Address 512 N. Carrollton Ave

19 MAY 22 1944 Humbert Williams M.D. Registrar
(Filed record in office)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19 1944 at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18/44 to 5/19 1944, and that I last saw h. alive on 5/19/44.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to (Hypertension)
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Haydon Howard
Address 1131 Harlem Ave Date signed 5/20/44

17426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17426 / 108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1354 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1354 Carroll St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Elizabeth Brown

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day hr.	min.
75				

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Evelyn Smith
(b) Address 1354 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Charles S. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) Date received by Local Registrar MAY 22 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-44 19 at 2' M

21. I certify that death occurred on the date above stated, that I attended deceased from 5-13-44 to 5-18-44, and that I last saw her alive on 5/16/44 19

Immediate cause of death Lobar Pneumonia — Duration 5 days

Due to Uremia

Due to "

Other Conditions Right Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation ?

Major findings of operation: —

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature J. J. Barksdale M. D.

Address 516 N. Carey St. Date signed 5/21/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 17427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No. G 17427

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Calverton Heights.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435. Calverton Heights.
(If rural give location).
(e) Citizen of foreign country? (Yes or No)
If yes, name country Italy.

3 (a) FULL NAME Vinciza Gaglione.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Salvador.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10.10.1860

8. AGE: Years 83 | Months 8 7 | Days 11 | If less than one day hr. min.

9. Birthplace Italy.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name S. Favaloro
13. Birthplace Itily

MOTHER
14. Maiden Name Not given
15. Birthplace

16 (a) Informant Son
(b) Address 2435 Calverton Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director George M. Fink & Son
(b) Address 1 W Wolfe St

19 (a) MAY 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21/44 19 7 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1915 to 5/21 1944, and that I last saw h- alive on 5/20 1944.

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to Pul. Hemiplegia	
Due to Cerebral Hemorrhage	7 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E N Haywood M. D.
Address 115 E Eager St Date signed 5/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G 17428

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 928

Reg. Dist. No. .....

G 17428

1. PLACE OF DEATH:

County .....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:
1810 Penrose Ave. V

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County .....

City or town Balto. City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1810 Penrose Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Charles Albert Mattingly

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ellen M.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 21, 1858

8. AGE:	Years	Months	Days	If less than one day
	86	-	-	..... hrs. ..... min.

9. Birthplace Lovgate Indiana
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business .....

FATHER 12. Name Hillery Mattingly

13. Birthplace Indiana

MOTHER 14. Maiden name Emily Favel

15. Birthplace Indiana

16. Informant Mrs. G.C. Barton

Address Walkersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25 1944 (month) (day) (year)

Cemetery or crematory New Cathedral

Location Baltimore

18. Funeral director G.C. Barton

Address Walkersville

MY 22 1944 (Date received by Local Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to May 21 1944

and that I last saw h.. alive on May 20 1944

		DURATION
Immediate cause of death	Cerebral thrombosis	2 days
	Mitral insufficiency	
Due to	Generalized arteriosclerosis	15 yrs
	C.V. Disease with hypertension	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operation .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? .....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John F. Coolahan M.D.
M. D. or other

Address 24 N. Fulton Ave. Date signed 5/22/44

G 17428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G 17428 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital. 9
(d) Length of stay in hospital or inst. ~~(yrs., mos., or days)~~ 3½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore.
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 East 39th St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lizzy W. BAKER.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/31/1872

8. AGE: Years 71 | Months 72 | Days 29 | 10 | 19 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation none.

11. Industry or business none.

FATHER
12. Name ~~William Baker~~ Wm. Berry Whitely
13. Birthplace Ballo. MD.

MOTHER
14. Maiden Name Annie Milby
15. Birthplace ~~Balto~~ Delaware.

16 (a) Informant daughter.- Miss E. Baker.
(b) Address (same)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23/44 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Loudon
Location Balto Md

18 (a) Funeral director Henry M Fenton (Inc) & McCullock Richards Co.
(b) Address

19 MAY 22 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 9.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1944, to 5/20 1944, and that I last saw her alive on 5/20 1944.

Immediate cause of death	Duration
cardio respiratory failure.	
Due to cerebral hemorrhage.	4 hrs.
Due to arteriosclerosis & hypertension.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas L. Coffee M. D.
Address UM Hospital Date signed 5/24/44

G 17430

AB-59708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17430 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs-7 mos-17days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Furrow St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Hiltner (John Henry Hiltner)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-09-5503

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. ~~Married~~ Widowed

6 (b) Name of husband or wife Sophie E. Stolsenbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18-1872

8. AGE: Years 72 | Months 2 | Days 1 | If less than one day ~~hours~~ min.

9. Birthplace Md. Baltimore Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John Hiltner
13. Birthplace Germany

MOTHER
14. Maiden Name Lizzie Yost
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAY 22 1944 Houston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1940 to 5-19 1944. That I last saw him alive on 5-19 1944.

Immediate cause of death: Coronary Occlusion — Duration: ?
Due to: Gen arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard A. Hebb M. D.
Address Balto City Hosp Date signed 5-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 17431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Clarkson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence J. Feeheley

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 213-10-1645

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife: Ethel L. Feeheley
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1898

8. AGE: Years	Months	Days	If less than one day
45	9	-	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Electrician Helper
11. Industry or business Henry J. Wurzbacher Co.

FATHER
12. Name Henry Jos. Feeheley
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Margaret Hergenhahn
15. Birthplace Balto. Md

16 (a) Informant Ethel L. Feeheley Wife
(b) Address 1710 Clarkson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Park
Location A. a. 60

18 (a) Funeral director A. Howard Evans
(b) Address 1100 S. Charles St

19 (a) May 23 1944 Registrar (Signature of local registrar)

WB 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944, at 7 05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Coronary Occlusion

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fontaine M.D. (Medical Examiner)
Date signed May 21 1944

G 17432 — BALTIMORE CITY HEALTH DEPARTMENT — G 17432 No. 1218

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 N. Wolfe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1894

8. AGE: Years	Months	Days	If less than one day
50	3	11	hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER — 12. Name: Thomas Watkins

13. Birthplace: Va.

MOTHER — 14. Maiden Name: Bettie Brasels

15. Birthplace: Va.

16 (a) Informant: Georgia Watkins

(b) Address: 1110 N. Wolfe St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: May 23 1944 (month) (day) (year)

(c) Cemetery or crematory

Location: Mt. Herrin Virginia

18 (a) Funeral director: Mrs. Roberta Elliott & Dgt.

(b) Address: 112 N. Caroline St.

19 (a) (b)

MAY 22 1944

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 44 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 19 44 to May 20 19 44 and that I last saw h[illegible] alive on May 19 19 44

Immediate cause of death	Duration
Myocarditis	7
Due to Chronic Glomerulo-nefritis	1
Due to	7
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: F. K. Adkins M. D.

Address: 1222 N. Caroline Date signed: 5-22-44

G 17433

JL- 56028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17433

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 11 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Maisel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hughes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Pressley (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7. ?1886

8. AGE: Years	Months	Days	If less than one day
58 ?	? 3	? 11	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bd. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Pulliam Funeral Service
(b) Address 421 E Fayette St

MAY 22 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1944 at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/18 1944, and that I last saw h. alive on 5/18 1944.

Immediate cause of death Bronchopneumonia — Duration 3

Due to

Due to

Other Conditions HCVD

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not yet

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seipman M.D.
Address BCH Date signed 5/24

Dr. Benj. Miller 2030 Wilkens Ave Bal 4306

17434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 17434

Please write the causes of death clearly and legibly. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Camillo De Luca

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Talia M. De Luca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1860

8. AGE: Years	Months	Days	If less than one day
53	6	8	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Stone Mason

FATHER
12. Name (Unknown) De Luca
13. Birthplace Italy

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lena McDougall
(b) Address 512 W. Franklin St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

MAY 22 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1944, at 1.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1944 to 5/21 1944 and that I last saw him alive on 5/21 1944.

Immediate cause of death	Duration
Arteria sclerosis Cardiovascular disease	1 yr
Due to	
Due to	
Other Conditions Cerebral hemorrhage	2 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] Benjamin Miller M. D.
Address 2032 Wilkens ave Date signed 5/23/44

17435 54877

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 46E

G 17435
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Blair Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-40

8. AGE: Years 3 1/2 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace D.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Carl Dixon
15. Birthplace Va.

MOTHER 14. Maiden Name Laura Honey
15. Birthplace Canada - Florida

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof May 23 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington DC
Location Washington DC

18 (a) Funeral director William W Chambers
(b) Address Washington D.C.

19 MAY 22 1944 Thurlington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to May 21 1944 and that I last saw h[illegible] alive on May 21 1944

Immediate cause of death: Respiratory failure — Duration

Due to: Reticulum cell sarcoma of intestine

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Koenig, M.D.
Address Johns Hopkins Hosp. Date signed 5/22/44

correct age is especially important. Physicians: please write clearly

G 17436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17436 Registered No.

PLEASE WRITE PLAINLY. Fill all blanks. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3670 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3670 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Mann

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie M. Mann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1871

8. AGE: Years	Months	Days	If less than one day
72	7	2	hr. min.

9. Birthplace Baltimore Maryland (Town, county, or state)

10. Usual Occupation Market Master

11. Industry or business Retired 3 Years

FATHER
12. Name George Wesley Mann
13. Birthplace Maryland

MOTHER
14. Maiden Name Charity P. Baldwin
15. Birthplace Maryland

16 (a) Informant C. Ernest Mann
(b) Address 4208 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Maria Hamden
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20- 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to May 20 1944. and that I last saw h[illegible] alive on May 19th 44.

Immediate cause of death Congestive Heart Failure — Duration

Due to Chr. Myocarditis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4027 Fell Rd. Date signed 5/23/44

G 17437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G 17437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 E. Mt Vernon Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME St. John Hamline Hartsock

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: ?

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ely Hartsock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1883

8. AGE: Years 60 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation: Medical Examiner

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Samuel Hartsock
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Mary E. Lewis
15. Birthplace: Maryland

16 (a) Informant: Mrs. Ely Hartsock
(b) Address: 20 E Mt Vernon Place Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-44 (month) (day) (year)
(c) Cemetery or crematory: Ivy Hill
Location: Laurel Md.

18 (a) Funeral director: The Wm. H. Donaldson
(b) Address: Md.

19 (a) MAY 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture base of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 20 1944 13:30 P.M.
(b) Where did injury occur? 2100 block Mt Royal Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury: Collision Jumped

23. Signature: Robert L. Fenton M.D. Medical Examiner
Date signed May 21 1944

correct age is especially important.

VS 151

C 17438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17438 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Fulton ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Levy (LEVI)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Harris Levi
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca —
15. Birthplace Russia

16 (a) Informant Maurice Levi (Bro)
(b) Address 903 Lake Drive

17 (a) burial (b) Date thereof 5-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cem
Location Southern Ave

18 (a) Funeral director Jos. Lewis Inc
(b) Address 4739 E. Balto. St

19 (a) MAY 22 19[illegible] Washington Wilkens, M.D.

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-1944, at 10-20 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions Chronic Valvular changes - Mitral + Aortic.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5/22/44

VS 151

G 17439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G 17439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital, 17
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Julia Whitehead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1904

8. AGE: Years	Months	Days	If less than one day
40	1	25	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Andrew Cheatham
13. Birthplace S. C.

MOTHER
14. Maiden Name Janie Hood
15. Birthplace S. C.

16 (a) Informant Samuel Cheatham
(b) Address 615 Gilbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.
18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.
19 (a) Date received (b) Washington Williams, M.D.

MAY 22 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 10 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944, to May 20 1944, and that I last saw h.er alive on May 20 1944.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to.....	
Due to.....	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation?.....
of autopsy: Pulmonary Embolism P&N

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature W. Z. Bamfield M.D.
Address Provident Hospital Date signed 5/27/44

G 17440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G 17440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 E. Centre Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 East Centre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eloise Neal Lyles

3 (b) If veteran, name war

3 (c) Social Security Account No. 246-22-7500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1920

8. AGE: Years	Months	Days	If less than one day
24	1	7	hr. min.

9. Birthplace Winston-Salem, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Western Electric

FATHER
12. Name Jefferson Neal
13. Birthplace N. C.

MOTHER
14. Maiden Name Bertha Graham
15. Birthplace N. C.

16 (a) Informant Samuel Lyles
(b) Address 104 East Centre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-44 (month) (day) (year)
(c) Cemetery or crematory
Location Winston-Salem N. C.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 558 W. Middle St.

MAY 22 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 20, 1944 19 , at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 19XX, to May 20 19XX, and that I last saw h.. alive on May 9 19XX

Immediate cause of death	Duration
Acute Nephritis	2 months
Due to La Grippe	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Williams Frey M. D.
Address 1928 Pa. Ave Date signed 5/22/44

correct age is especially important. Physicians, please write

VS 150

Huntington Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V161C

Registered No. G 17441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 Hayward Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Hayward Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unnamed Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22

8. AGE: Years | Months | Days | If less than one day 1 hr. min.

9. Birthplace 3512 Hayward Av Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jones
13. Birthplace

MOTHER 14. Maiden Name Rosaline
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 2

0969

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944, to May 22 1944, and that I last saw h-im alive on May 22 1944

Immediate cause of death	Duration
Hemorrhage from Mouth	1 hour
Due to (Unknown)	
Due to	
Other Conditions Difficult Respiration	1 hour

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence — NO at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J Weller M.D.
Address 5276 Park Ht Av Date signed May 22 44

G 1742 — G 1742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. .....

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and legibly. Give full name of street and number. Be sure to answer each question. Do not omit any item if you can obtain the information. Please see that your certificate is complete and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Calvert Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Dr. James Burch Joyce

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife Flora Bolgiano
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 15 Nov. 1872

8. AGE: Years	Months	Days	If less than one day
71 72	6	6	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER — 12. Name Cyrus N. Joyce
13. Birthplace Maryland

MOTHER — 14. Maiden Name Liza Jane Collinson
15. Birthplace Maryland

16 (a) Informant Mrs. Fred A. Weis, Jr.
(b) Address 3809 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North Ave. Greenmount

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1905 Eutaw Place

19 (a) ..... (b) ..... Registrar

Date received MAY 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 May 1944 at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 May 1944, to 21 May 1944, and that I last saw him alive on 21 May 1944.

Immediate cause of death Cardiorespiratory failure — Duration .....

Due to Embarrassment of Cardiac 4 days — Duration .....

Due to Hypertensive cardiovascular disease — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature George W. Humphreys Jr. M. D.
Address Union Memorial Hospital Date signed 5-21-44

D17443

458048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17443

Registered No. 554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford Co.
(c) City or town Fallston R.F.D. 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Marion Butler Ewald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lawrence

6 (c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.) 6-22-1910

8. AGE: Years 33 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Conn. (Town, county, and state)

10. Usual Occupation Artist

11. Industry or business

FATHER — 12. Name George E. Butler

13. Birthplace Mass.

MOTHER — 14. Maiden Name Margaret Vautier

15. Birthplace Pa.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24/44 (month) (day) (year)

(c) Cemetery or crematory Location East Hadden Conn

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1901 Eutaw Place

19 (a) MAY 22 1944 Huntington Mitchell Jones, M.D. Johns Hopkins

VS 160

MEDICAL CERTIFICATION 35

20. DATE OF DEATH May 22 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944 to May 22 1944 and that I last saw h[illegible] alive on May 22 1944.

Immediate cause of death	Duration
Respiratory Failure	10 min
Pulmonic consolidation	48 hrs
Due to: ? Pulmonary Embolism	48 hrs
? Lobar Pneumonia	
Due to Recurrent Lymphosarcoma	16 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Dickson M.D. M. D.

Date signed 5 22 44

Please fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17444 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5300 Merceron Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5300 Merceron Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Spellissy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or ~~wife~~ Martin M. Spellissy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1873

8. AGE: Years 71 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Zimmerman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Garth
15. Birthplace Baltimore Md.

16 (a) Informant John R. Spellissy
(b) Address 5300 Merceron Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave

19 (a) (Signature of registrar)
MAY 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1944, at 6.50 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1943, to May 18 1944, and that I last saw h e c alive on May 15 1944

Immediate cause of death
1) Cerebral Sclerosis
Heart Disease

Duration 5 yrs.?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4105 Liberty Hts Date signed 5/18/44

Note the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 17445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17445 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Ridgehill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Jenkins (Eleanor Marion Jenkins)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Jacob W. Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8/4/14

8. AGE: Years: 29 | Months: 9 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Clarence E. Pletzer
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Georgia Scott
15. Birthplace: Md.

16 (a) Informant: Mr. Jacob W. Jenkins
(b) Address: 1911 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 5/24/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Baltimore, Md.

19 5-22-1944 Huntington Williams, M.D.
(a) (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/1944, to 5/21/1944, and that I last saw her alive on 5/21/1944.

Immediate cause of death	Duration
Pulmonary Embolus	
Due to Thyrotoxicosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/20/44

Major findings of operation: Thyrotoxicosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Herman Sol. Chesket M.D.
Address WBGH Date signed 5-24-44

G 17446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17446 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2856 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2856 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LAVINIA THATCHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William T. Thatcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1859

8. AGE: Years	Months	Days	If less than one day
84	7	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business Henry

FATHER
12. Name John Robinson
13. Birthplace ~~Unknown~~ Middlesex Co. Va

MOTHER
14. Maiden Name Mary Ellen England 1920
15. Birthplace Md. Lord Calvert Talbot Co

16 (a) Informant Mr. Francis Thatcher
(b) Address 2856 W. North Ave.

17 (a) Burial (b) Date thereof 5/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

MAY 22 1944 (c) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 21, 1944 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944 to May 21 1944, and that I last saw h[illegible] alive on May 14 1944.

Immediate cause of death	Duration
Myocarditis	
Senility	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M E Needle M. D.
Address 2314 - W North Ave Date signed 5/24/44

G 17447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17447

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 919 W. North Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JAMES DAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Catherine J. Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1888

8. AGE: Years	Months	Days	If less than one day
56	0	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Ice Business
11. Industry or business Self

FATHER
12. Name Nicholas Day
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Fowler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine J. Day
(b) Address 3309 Parkington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 22 1944 (a) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1944, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to 5/21 1944, and that I last saw h[illegible] alive on 5/20 1944

Immediate cause of death Coronary disease — Duration sudden

Due to

Due to

Other Conditions Diabetes — Contributory means of Trouble — 4 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1901 Eutaw Pl Date signed 5/22/44

G 17448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17448 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE CARTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William T. Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1893

8. AGE: Years	Months	Days	If less than one day
50	5	0	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Martin J. Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine O'Neill
15. Birthplace Ireland

16 (a) Informant Mr. William T. Carter
(b) Address 928 W. North Ave.

17 (a) Burial (b) Date thereof 5/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 22 1944 Thos. J. Milhaupt, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May 20, 1944, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7, 1944 to May 20 1944 and that I last saw h[illegible] alive on May 19 1944

Immediate cause of death	Duration
Acute Coronary disease	Late
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Palmer Baugh M.D.
Address 1901 E. Fayette St Date signed May 22 1944

Write the cause or causes clearly and legibly. Physicians, please write in ink. Cause is especially important.

G 17449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17449 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Harford Ave.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN H. GETTEMULLER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary C. Gettemuller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 16, 1874
8. AGE: Years 69 | Months 10 | Days 4 | If less than one day hr. min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry J. Gettemuller
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Merle
15. Birthplace N. Y.

16 (a) Informant Mrs. Mary C. Gettemuller
(b) Address 3112 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 22 1944 (Date received by Registrar) (b) Washington Millington M.D. (Signature)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 20, 1944 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944 to May 20 1944 and that I last saw h alive on May 19 1944

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Arteriosclerosis
Due to:
Other Conditions: Severe Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph Heroglotz M. D.
Address 3047 W Cold Date signed 5/22/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.3 days 11 yrs. 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days 11 yrs. 9 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town Washington, D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3472 - 14th Street, N.W.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ...

3 (a) FULL NAME Hannah J. Donovan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Dead
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 9, 1865

8. AGE: Years	Months	Days	If less than one day
78	11	12	11 hr. 0 min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Barrett
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Berrett
15. Birthplace Ireland

16 (a) Informant Hosp. Records
(b) Address

17 (a) Removal (b) Date thereof 5/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 22 1944 (b) ... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1932, to May 22 1944, and that I last saw her alive on May 22 1944.

Immediate cause of death	Duration
Nephritis with hypertension	10 yrs.
Due to Diabetes Mellitus	10 yrs.
Due to	
Other Conditions Arteriosclerotic degeneration	12 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dawson Fillagra M. D.
Address 3326 14th St. N.W. Date signed

VS 3

G 17451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G 17451 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 Caswells St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Caswell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George H Herskenheim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 74 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Watchman

FATHER — 12. Name George H Herskenheim
13. Birthplace Baltimore

MOTHER — 14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs Pauline Herskenheim
(b) Address 1736 Caswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Mary M Treadwell
(b) Address 201 E. 22nd St

19 (a) 1944 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 20 1944, at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 20 1944 and that I last saw him alive on May 20 1944

Immediate cause of death

Due to Hypertension Cardiac Renal Disease — Duration: 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fritz J Illmer
Address 2700 Norford Rd Date signed 5/ M. D.
May 2

Please write the causes of death clearly and legibly. Physicians: please write to correct age is especially important.

17452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 17452 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Aubrey J. Stem, Senior

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife ~~Charlotte~~ Stem
deceased (If married, widowed, or divorced give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1875

8. AGE: Years	Months	Days	If less than one day
69	3	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

MOTHER / FATHER
12. Name Joseph T. Stem
13. Birthplace Md.
14. Maiden Name Charlotte Wilt
15. Birthplace Md.

16 (a) Informant Aubrey Stem, Jr.
(b) Address Westminster, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Winfield, Carroll Co. Md.

18 (a) Funeral director C. M. Watts
(b) Address Winfield, Md.

19 (a) Date received (b) Registrar

MAY 23 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944, at 10:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 1944, to May 21, 1944, and that I last saw h[illegible] alive on May 21, 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Congestive heart failure

Due to

Other Conditions Uremia, Pneumonia
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Bazlinski, M. D.
Address Mercy Hospital Date signed 5.21.44

17453 Budravich ✓ G 17453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Budravich

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 216-05-4236

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16. (a) Informant Vincent Budravich
(b) Address 2418 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 XX (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director Joseph Rasmuskas Inc.
(b) Address 602 [illegible]

19 MAY 23 1944 (Date rec'd by Local Registrar)
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21- 19XX, at 5 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured Cervical vertebrae

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-21-44 at 3 A M.
(b) Where did injury occur? 2418 W. Lombard St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down stairs - way.

23. Signature Howard J. Wilson M.D.
Medical Examiner.
Date signed 5-22-44

17454

AB-88085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 17454

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 South Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius Chepuli

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1880

8. AGE: Years 64 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore Rd.

18 (a) Funeral director Joseph Kaunskas J.M.
(b) Address 620 Washington Blvd.

MAY 23 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1944, at 8.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1944 to 5/19 1944 and that I last saw him alive on 5/19 1944

Immediate cause of death Cerebral hemorrhage — Duration 2d.

Due to HTN CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M. D.

Address BCH Date signed 5/20

Correct age is especially important. Physician will please write the cause of death clearly and legibly.

G 17455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G 17455 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Frankford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Frankford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rafael Quinones (Ralph A. Quinones)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy E. Quinones

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1898

8. AGE: Years 45 | Months 6 | Days 28 | If less than one day: hr. min.

9. Birthplace: San Gernen, Puerto Rico
(Town, county, and state)

10. Usual Occupation: ?

11. Industry or business: Montgomery Ward

MOTHER | FATHER

12. Name: Rosendo Quinones

13. Birthplace: Puerto Rico

14. Maiden Name: Juanita Irizarry

15. Birthplace: Puerto Rico

16 (a) Informant: Rosendo Quinones

(b) Address: Biltmore Hotel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-1944 (month) (day) (year)

(c) Cemetery or crematory: Parkwood

Location: Baltimore

18 (a) Funeral director: Henry Sander & Sons, Inc

(b) Address: North Ave. , Broadway

MAY 23 1944
(Date rec'd by registrar) (b) Burlington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of brain

Due to:

Other Conditions: Dependent.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-22- at 5 A M.

(b) Where did injury occur? 4311 Frankford Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Self inflicted gun shot wound

23. Signature: Howard J. Williams M.D.
Medical Examiner.

Date signed 5/22/44

G 17456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

G 17456 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 N. Stemwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 N. Stemwood ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charles H Stromberg

3 (b) If veteran, name war: | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Stromberg
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Drug Clerk
11. Industry or business Druggist

FATHER 12. Name August Stromberg
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Bostic
15. Birthplace Germany

16 (a) Informant: Anna M Stromberg
(b) Address 734 N. Stemwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave

18 (a) Funeral director Henry Lutz
(b) Address 1203 N. Broadway

19 (Date rec'd by registrar) MAY 23 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 4 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to May 20 1944, and that I last saw h[illegible] alive on May 20 1944.

Immediate cause of death: Coronary Thrombosis. — Duration 5/19/44

Due to: Arteri - Sclerosis. Mitral Insufficiency — 1 yr. 1 yr.

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumeich, M. D.
Address 722 N. Kenwood Ave Date signed 5/24/44

VS 3

G 17457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 17457

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 Oswego Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Zbagil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Reverend
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Jaypie
15. Birthplace Russia

16 (a) Informant Leah Zbagil
(b) Address 2719 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-44 (month) (day) (year)
(c) Cemetery or crematory Russdale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 173 N. Balti.

MAY 23 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH V- 22 1944 at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to May 22 1944 and that I last saw h. alive on May 22 1944

Immediate cause of death Carcinoma Colon with metastases | Duration Hours

Due to | ?

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.B. Kirsh, M.D. Registered Physician
Address 2904 Reisterstown Rd. Date signed 5/24/44

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

VS 150

17458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G 17458 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2744 E. Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Gerard Guttenberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-44-9 00 PM

8. AGE: Years | Months | Days | If less than one day: 15 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Joseph Guttenberger
13. Birthplace Rossville Md.

MOTHER 14. Maiden Name Anna Marion Dreschler
15. Birthplace Baltimore Md.

16 (a) Informant George J. Guttenberger
(b) Address 2744 Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorsuch Hill Road

18 (a) Funeral director Lilly and Geisler, Inc
(b) Address 4039 Wolfe St.

MAY 23 1944 (Date received by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 19 44, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-[illegible] 1944 to 5-22 1944, and that I last saw him alive on 5-22 19 44.

Immediate cause of death: Duration

Due to: Cerebral Hemorrhage 15 hrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. J. Kenny M.D.
Address Bon Secours Hosp. Date signed 5/23/44

PLEASE ... and causes of death clearly and legibly. Physician: please write correct age is especially important.

17459

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 56 V

G 17459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Bon-Secour Hosp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset Co.
(c) City or town Princess Anne. (If outside city or town limits, write RURAL and give town)
(d) Street No. Somerset Co. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Evans

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: FEM
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Enos Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1902

8. AGE: Years 41 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Dryden
13. Birthplace Md

MOTHER
14. Maiden Name Cora King
15. Birthplace MD

16 (a) Informant ENOS EVANS
(b) Address PRINCESS ANN.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25-44 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem
Location Princess Anne Md

18 (a) Funeral director Dale Dashiell
(b) Address Princess Anne.

19 MAY 23 1944 Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1944 at 2.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1944 to 5/23 1944 and that I last saw h.er alive on 5/23 1944.

Immediate cause of death Peripheral circulatory failure — Duration 24 hrs
Due to Pelvic Peritonitis — 2 days
Due to (acute)
Other Conditions Paralytic Ileus
(Include pregnancy within 3 months of death)
Date of operation 5/19/44
Major findings of operation: Myomata Uterus.
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify)
(e) Means of injury —
23. Signature Edmund Lowe, M. D.
Address Bon Secour Hosp Date signed 5/23/44

correct age is especially important. Physicians, please answer questions carefully.

VS 8

G 17460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G 17460 Registered No.

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2640 W. North ave
(c) Hospital or institution: — —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2640 W. North ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) **FULL NAME** Lester Raymond Dalkey.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 22 - 1944

8. AGE: Years | Months | Days | If less than one day: 10 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant — None

11. Industry or business —

FATHER
12. Name William Dalkey
13. Birthplace Md

MOTHER
14. Maiden Name Anna Baker.
15. Birthplace Md

16 (a) Informant Mrs. William Dalkey
(b) Address 2640 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mem.
Location Woodlawn Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) (Date received by Registrar) MAY 23 1944 (Registrar) Whitington

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, 8.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944, to May 22 1944 and that I last saw h. imalive on May 22 1944

Immediate cause of death: Atelectasis — Duration: 10 Hrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature R. C. Allen M.D.
Address 2757 W. North Date signed 4th D. 5/23/44

214949 G 17461 ✓ G 17461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Fredric W. Cone (Frederic W. Cone)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: ?
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-27-78
8. AGE: Years 65 | Months 8 | Days 24 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Merchant Retd.
11. Industry or business

FATHER
12. Name Herman Cone
13. Birthplace Germany

MOTHER
14. Maiden Name Eff Guggenheimer
15. Birthplace Germany

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Edward Sonnborn & Sons
(b) Address 120 N. Eutaw Place

19 (a) Date received MAY 29 1944 (b)
Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1944, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1944 to 5-20 1944 and that I last saw h/her alive on 5-20 1944

Immediate cause of death: a. Carcinoma of urinary bladder — Duration

Due to:

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell R. Reed M. D.
Address Johns Hopkins Hosp. Date signed 5-20-44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 17462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G 17462 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2541 Francis St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) B
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 Francis St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Sanders

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Frank Klein Sanders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1- 1868

8. AGE: Years 76 | Months — | Days 21 | If less than one day hr. min.

9. Birthplace Manchester Carroll Co. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Chas. F Falkenstein
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura Beltz
15. Birthplace Manchester. Md.

16 (a) Informant Mrs. Flora Baumgartz
(b) Address 2541 Francis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Fuhrman & Son
(b) Address Balto, Md.

MAY 23 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 6:5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to May 22 1944 and that I last saw h.. alive on May 21 1944

Immediate cause of death: Cerebral Hemorrage — Duration 5/6/44

Due to: Chr. Valvular Heart disease. Mitral Insufficy — 1940

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Simon

Address 1636 W. North Ave Date signed 5/25/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 17463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G 17463 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden ave
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4116 Oakford Ave. #15 (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cornelia F. Hessel (or Hesselmeyer)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Arthur C. Hessel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 8, 1873
8. AGE: Years 70 | Months 6 | Days 13 | If less than one day hr. min.
9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore Hesselmeyer
13. Birthplace N. Y.

MOTHER
14. Maiden Name Dorothea Krebill
15. Birthplace N. Y.

16 (a) Informant Mrs. J. F. Lamcke
(b) Address 4116 Oakford Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 23 1944
(Date rec'd by reg.) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 1944, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1944, to 5-21 1944, and that I last saw h[illegible] alive on 5-21 1944.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions: Healing fracture rt. hip
(Include pregnancy within 3 months of death)

Date of operation (none)

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Feb 24, 1944 at — M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell, tripped on linoleum

23. Signature John D. Young Jr. M. D.
Address Md. Gen. Hosp. Date signed 5-21-44

VS 186 For S.P.J. Zdunski, by Horace J. Lemmon M.D.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G 17464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17464 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5527 Frederick Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5527 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA CATHERINE MESSERSMITH

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1860

8. AGE: Years: 83 | Months: 7 | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Charles Messersmith
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Saumenig
15. Birthplace Maryland

16 (a) Informant Mrs. Amelia B. Creasley
(b) Address 5527 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 MAY 23 1944 (Date rec'd by registrar) (b) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1944, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16, 1934, to May 22, 1944, and that I last saw her alive on May 22, 1944.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H. Kemp, M.D.
Address 3030 Edmondson Ave. Date signed 5/23/44

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

453483
G 17465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G 17465
Registered No.

1. PLACE OF DEATH:
(a) City Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Lewis Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-00

8. AGE: Years 43 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Perry Cooper
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah J.
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blankenship Ave

19 MAY 23 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 6.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944 to May 20 1944, and that I last saw him alive on May 20 1944

Immediate cause of death	Duration
Tuberculous meningitis	2 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Date signed 5-21-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G 17466 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Forman Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Forman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Knotts

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 58 Months Days If less than one day hr. min.

59

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace

MOTHER
14. Maiden Name unobtainable
15. Birthplace

16 (a) Informant Rossevelt Knox
(b) Address 1807 Lorman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Md.
Location

18 (a) Funeral director Geo. C. Kelson
(b) Address 1303 Presstman S.,

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-1944, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moldeis M.D.
Medical Examiner.

Date signed 5-22-44

17467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17467
Registered No.

70 #81487

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 W. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1896

8. AGE: Years 48 47? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Unable to obtain further
11. Industry or business information.

FATHER
12. Name William Jackson
13. Birthplace Georgia

MOTHER
14. Maiden Name Betty Jackson ?
15. Birthplace Georgia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Daniel L. Downs & Son
(b) Address 105 W Montgomery St

19 (c) MAY 23 1944 (Date received by Registrar) Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1944, at 9:25P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/18 1944 and that I last saw him alive on 5/18 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	?
Due to H.C.V.D.	
Due to	
Other Conditions Gen. arteriosclerosis; chr. emphysema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. L. Seigman M. D.
Address BCH Date signed 5/22

G 17468

AB-84842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

G 17468

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.-7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Bradley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Area Giles or Aaron Giles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5-1877

8. AGE: Years 67 | Months - | Days 14 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER
12. Name Joseph Giles
13. Birthplace Md.

MOTHER
14. Maiden Name Pinkney Herriett
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Belnord Ave.

19 (a) MAY 23 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19- 1944 at 6.42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1944 to 5/19 1944 and that I last saw him alive on 5/19 1944.

Immediate cause of death: Miliary TBC — Duration: 3 / 1

Due to

Due to

Other Conditions: Syphilis, latent

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: miliary spread to liver

of autopsy: also lungs, kidneys, etc

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman

Address BCH Date signed M. 5 D. 22

G 17469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G 17469

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Co
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Sycamore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard A. Jones Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rosetta Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 24 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Sparrows Point Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethelhem Steel

FATHER 12. Name Howard A Jones Sr

13. Birthplace Va

MOTHER 14. Maiden Name Marian Williams

15. Birthplace Va

16 (a) Informant Rosetta Jones

(b) Address 2508 Sycamore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)

(c) Cemetery or crematory M-Calvary

Location G.A.C. Co

18 (a) Funeral director Sam'l H. Chase & Son

(b) Address 658 N. Gilmor St

19 (a) MAY 23 1944 Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

45

20. DATE OF DEATH May 21 1944, at 1 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wounds of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury May 21 1944 12 AM. #5

(b) Where did injury occur? Polo Tavern

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Gunshot wounds

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed May 21 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 17470 — CERTIFICATE OF DEATH — 108 G 17470

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 McCulloh St.; 4/12 Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Beatrice Singleton Graham — If U. S. Veteran specify WAR

(a) Residence: No. 2432 N. Pearl St., ... Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wilton Graham

6. DATE OF BIRTH (month, day, year) Dec 1922

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
21	8		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Walton W. Va.

FATHER

13. NAME Dan Singleton

14. BIRTHPLACE (city or town) (State or country) Jamaica Florida

MOTHER

15. MAIDEN NAME Julia Grister

16. BIRTHPLACE (city or town) (State or country) Riverside S.C.

17. INFORMANT Mrs Pauline Yates (Address) 714 Bladen St. Wilmington N.C.

18. BURIAL, CREMATION, OR REMOVAL Place Woodlawn Date 5-25 1944

19. UNDERTAKER Mrs. Katie R. Williams (Address) 2222 N. Belnord Ave

20. FILED MAY 23 1944 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 5-21-, 1944

22. I HEREBY CERTIFY, That I attended deceased from 5-8-, 1944 to 5-20, 1944

I last saw her alive on 5-20, 1944 Death is said to have occurred on the date stated above, at 6 A.M.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
Pneumonia	3 days
Other contributory causes of importance: Bronchitis	14 "

Was an operation performed? no Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Medical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury 19..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) J. H. Walters M.D.

(Address) 2174 McCulloh St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 17471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17471 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 E LaFayette Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 E. LaFayette Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Schade

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Godfrey L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1877

8. AGE: Years	Months	Days	If less than one day
67	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Frederick Barlag
13. Birthplace Md

MOTHER
14. Maiden Name Annie Shroad
15. Birthplace Md

16 (a) Informant Mrs. Godfrey L. Schade Jr.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 44 (month) (day) (year)
(c) Cemetery or crematory Oakdown
Location

18 (a) Funeral director Lemmon Heyde & Rd
(b) Address 5325 Harford Rd

19 (a) (b) Huntington Williams, M.D. Registrar

MAY 23 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to May 21 1944 and that I last saw h.. alive on May 21 1944.

Immediate cause of death Hypertension C-V disease — Duration 5 yrs.

Due to

Due to

Other Conditions Acute pulmonary edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. N. Krampf

Address 1428 Kenyon Rd Date signed 5-23-44

17472

AB-81708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G 17472
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos. 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1083 Elliott Drive (or rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Hahn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Wilhemmenia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11-1878

8. AGE: Years 65 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Marshall Hahn
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Gaylord (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore,

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd,

MAY 23 1944 (b) Huntington Millhouse, Md.
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/21 1944
and that I last saw h[illegible] alive on 5/21 1944

Immediate cause of death
(a) Coron. Arteriosclerosis
Due to
(b)
Due to
(c)

Duration

Other Conditions ASCVD; prostate nodulus; and emphysema
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Engman M. D.
Address BCH Date signed 5/22

G 17473 HERMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17473 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 Glyndon Falls Pkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 13th
(If outside city or town limits, write RURAL and the town)
(d) Street No. 1637 Glyndon Falls Pkway
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Benj. Herman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER 12. Name Calman Goodman

13. Birthplace Russia

MOTHER 14. Maiden Name Gerzia Kaya

15. Birthplace Russia

16 (a) Informant Murray Herman

(b) Address 1637 Glyndon Falls Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)

(c) Cemetery or crematory Mt Sinai Hebrew Cong

Location Pikesville Baltimore Co

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1439 E. Balto St

19 MAY 23 1944 (Date rec'd by registrar) (b) [illegible] M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-44 19 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1942 to 5/22 1944 and that I last saw him alive on 5/22 1944.

Immediate cause of death	Duration
UREMIA	
BRONCHOPNEUMONIA	
Due to ARTERIOSCLEROTIC CURH) GENERALIZED ARTERIO SCLEROSIS	
Due to CEREBRAL ARTERIOSCLEROSIS (MARKED)	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Willard Appleford

Address 2511 Reisterstown Rd Date signed 5/22/44 D.

VS 3

G 17474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G 17474 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 - E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give township)
(d) Street No. 1720 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Fackler

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Harry Jacob.
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1888

8. AGE: Years	Months	Days	If less than one day
55	7	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name Adam Ryeling
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Dryfler
15. Birthplace Balto. Md.

16 (a) Informant Mr. Harry J. Fackler
(b) Address 1720 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Elmer W. Conkling & Son
(b) Address 924 E. Eager St.

19 (a) [redacted] Registrar

MAY 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1944 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1942 to 5/23 1944 and that I last saw her alive on 5/23 1944

Immediate cause of death Uremia — Duration

Due to carcinoma of the bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas K. Yalowitz M.D.
Address 113 - W. Monument St. Date signed 5/24

correct age is especially important. Physician: please write the cause of death clearly and legibly.

WPB 150

G 17475

G 17475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Jankulski (Janki)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1942

8. AGE: Years 1 | Months 8 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Jankulski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Frances Goodman
15. Birthplace Baltimore

16 (a) Informant Frances Jankulski
(b) Address 1614 Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) (Date received by registrar) MAY 23 1944 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Vegetative endocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gutstein M.D.
Medical Examiner,
Date signed May 23, 1944

17476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161a

G 17476
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.A. Providence Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Whatcoat k.o.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Fenwick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex C

5. Color or race F

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 23 1944 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1944, at 1.40 P M

21. I certify that I took charge of the remains described above, held an Inquiry-Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis Neonatorum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hunter J. Tulbrandsen M.D.
Medical Examiner.
Date signed 5/20/44

0971

17477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17477
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fountain & Caroline Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 23 1944 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1937, at 12:35 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis cardiovascular
Due to disease
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed May 9, 1937.

VS 151

0970

G 17478-4257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 17478 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: John Hopkins Hosp. W

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1303 Pennsylvania Ave (If rural give location)

(e) Citizen of foreign country? a..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Joseph Smallwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-22-09

8. AGE: Years	Months	Days	If less than one day
34	4	29	hr. ; min.

9. Birthplace Md - (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Jim Smallwood

13. Birthplace Md -

14. Maiden Name Mary Carroll

15. Birthplace Md -

16 (a) Informant Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto; Md

18 (a) Funeral director Chas. F. Law

(b) Address 802 Madison Ave

19 (a)..... (b)..... (Signature of registrar)

MAY 23 1944 Registrar's No. Huntington Md. District No.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1944 at 6 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to May 21 1944 and that I last saw h[illegible] alive on May 21 1944

Immediate cause of death

Pneumonia

Duration 6 wks

Due to.....

Due to.....

Other Conditions Thrombocytopenia

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury.....

23. Signature H H Carlin M.D.

Address Johns Hopkins Date signed 5-22-44

Please fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17478 454043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17478
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Ship Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gene Closser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-22-43

8. AGE: Years | Months 45 | Days - | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Eugene Closser

13. Birthplace Penn

14. Maiden Name Rachael Cooper

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 (month) (day) (year)

(c) Cemetery or crematory Pine Grove Cem

Location Parkton Md

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Arlington Ave

MAY 23 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 8:14 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 10 1944 to MAY 22 1944, and that I last saw her alive on 19

Immediate cause of death: Cardiac Failure — Duration: 2 wks

Due to Pneumonia, and Septicemia — Duration: since birth

Due to

Other Conditions Congenital Heart lesion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Multiple small lung abscesses

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L Dobson M.D. M. D.

Address Johns Hopkins Hosp Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17480

JL - 88102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/21a

G 17480 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: altimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 301 S. Conkling St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cosimina Carrie Giordano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1890

8. AGE: Years 54 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ~~XXXXXXXXXX~~ Dominic Catalano

FATHER 13. Birthplace Italy

MOTHER 14. Maiden Name ~~XXXXXXX~~ Anna Leone

MOTHER 15. Birthplace Italy

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Anne Arundel Co.

18 (a) Funeral director Grauel Della Rose

(b) Address 52 N. Morley St.

19 (a) MAY 23 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1944 at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 1944 to 5/22 1944, and that I last saw her alive on 5/22 1944.

Immediate cause of death Uremia, cardiac failure

Duration 5 d.

Due to HCVD & decomp; nephrosclerosis

Due to

Other Conditions Pyelitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Sigman M.D.

Address BCH Date signed 5/22

G 17481 G 17481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Patapsco St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Md
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Patapsco St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E Simmons

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joshua Simmons
(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1866

8. AGE: Years 77 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace Salisbury Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Wilson
13. Birthplace Salisbury Md

MOTHER
14. Maiden Name Unica Betts
15. Birthplace Salisbury Md

16 (a) Informant Joshua Simmons
(b) Address 1735 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 (month) 1944 (year)
(c) Cemetery or crematory Cedar Hill
Location A-A 60

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles St

19 (a) [illegible] registrar Hampton Mihaus, M.D.

NOV 23 1944
Vs 12

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944 at 5 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 43 to May 22 1944, and that I last saw h[illegible] alive on May 22 1944.

Immediate cause of death: Acute dilatation of heart & Asphyxia — Duration: 2 days

Due to: Mitral Regurgitation — Duration: Indef.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature H. E. L. Campbell

Address 1646 Hanover St Date signed May 23 1944

G 17482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 927

G 17482 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Barbara Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Simon Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18-1859

8. AGE: Years 84 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired Housewife

FATHER
12. Name Ferdinand Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Schmidt
15. Birthplace Germany

16 (a) Informant Frank E. Fuller
(b) Address 713 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24-1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director George L. Schyrer
(b) Address 710 Frederick Ave

19 (a) (b) Huntington Mathews, M.D. Registrar

MAY 24 1944

VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH May 21 1944 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1944 to 5/21 1944, and that I last saw her alive on 5/20 1944

Immediate cause of death	Duration 2 days
Coronary Occlusion	
Due to Myocarditis	2
Due to Arteriosclerosis	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James H. Lowenburg M.D.

Address 724 Mulberry St Date signed 5/22/44

Correct age is especially important

No. 17488
87924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 17488
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. Locust Point 153 Boyle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bates

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband or wife: Mary A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 17, 1872
8. AGE: Years 71 | Months 6 | Days 5 | If less than one day hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Buck Glass Co.

FATHER
12. Name John Bates
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha AKehurst
15. Birthplace England

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location Baltimore
18 (a) Funeral director Wm Cook Inc
(b) Address 1217 to Park Ave
19 MAY 24 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 | 22 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 | 10 1944 to 5 | 22 1944 and that I last saw living on 5 | 22 1944

Immediate cause of death: Lobar pneumonia — Duration: 5 days
Due to:
Due to:
Other Conditions: Gen. arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address BCH Date signed 5/23

(OVER)

VS 150

Please write the causes of death clearly and legibly. Physician: please write correct age is especially important.

G 17489 ✓ G 17489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5223 St. Charles Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5223 St. Charles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vinton O. Baker

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Alice Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1881

8. AGE: Years 63 | Months 1 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation: Printer

11. Industry or business: Arthur Thomkson

FATHER
12. Name: (Unknown) Baker
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant: Alice Baker
(b) Address 5223 St. Charles Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 5/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MAY 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 5 40 AM

21. I certify that I took charge of the remains described above, held an Autopsy, ~~Inspection~~ or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions Chronic chol cystitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 25 1944

Please write the causes of death clearly and legibly. Physicians: please write in ink. Any unpleasantness in obtaining information will be avoided by complying with this request.

G 17490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G 17490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Lehigh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robert Hynson

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3.23.42

8. AGE: Years 2 | Months 21 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Henry W. Hynson

13. Birthplace Balto

MOTHER 14. Maiden Name Evelyn Rooney

15. Birthplace Baltimore

16 (a) Informant HENRY W. HYNSON (FATHER)

(b) Address 623 S. LEIGH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 26/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeibi Sons

(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) (Registrar)

MAY 24 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944, to MAY 22 1944, and that I last saw him alive on May 22 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Meningitis, Tuberculous	22d.
Due to Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul L. Wilson M. D.

Address Sydenham Hosp. Date signed 5-23-44

G 17491 AB-88135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G-17491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 221 S. Ellwood Ave. (or location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DANIEL M. REAGAN

3 (b) If veteran, name war: W.W.#1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 3 1891

8. AGE: Years	Months	Days	If less than one day
52?	10	11 18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation SEAMAN
11. Industry or business

FATHER
12. Name JOHN J. REAGAN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELIZA DUNCAN
15. Birthplace BALTO. MD.

16 (a) Informant Baltimore City Hospitals Records
(b) Address
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 25/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD
18 (a) Funeral director Lilly and Zeiler, INC.
(b) Address 403 S. WOLFE ST.
19 (a) (b)

MAY 24 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944, at 6.25 M
21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1944 to 5/21 1944 and that I last saw h[illegible] alive on 5/21 1944.

Immediate cause of death	Duration
Acute nephritis	
Due to	
Due to	
Other Conditions Arteriosclerosis (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy: as above; hypertension; cerebral edema; pneumonia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Sugmon M. D.
Address BCH Date signed 5/22

G 17492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17492
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Sinai Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH WEINSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Morris J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Houe Work

FATHER
12. Name Joseph Brofsky
13. Birthplace Russia

MOTHER
14. Maiden Name Tena ?
15. Birthplace Russia

16 (a) Informant Morris J Weinstein
(b) Address 3807 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E. Baltimore St 3600

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W. North Avenue

19 (a) MAY 24 1944 (b) Huntington Woodbridge
Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23 1944, at 6 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1944 to 5-23 1944, and that I last saw h.e.r. alive on 5-23 1944

Immediate cause of death Cardiac Insufficiency — Duration

Due to Arteriosclerotic Heart disease with

Due to Coronary insufficiency

Other Conditions Chr. Rheumatoid Ulcer Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 5-23-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Sinai Hosp Date signed 5-23-44 M. D.

G 17493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17493 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E. 23 th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-28 40 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E. 23 St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Frank
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 17 1888
8. AGE: Years 56 | Months 4 | Days 6 | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Hyman Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Unknow
15. Birthplace Russia

16 (a) Informant Mrs. Lena Frank
(b) Address 501 E. 23 th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane
18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W. North Ave
19 (a) (b)
(Date rec'd by registrar) MAY 24 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 2.A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1941, to May 23 1944 and that I last saw [illegible] alive on May 23 1944

	Duration
Immediate cause of death: Coronary Thrombosis	1 hour
Due to: Coronary Sclerosis	6-7 yrs.
Due to:	
Other Conditions: Hyper Tension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myndon Cooper M.D.
Address 2107 Park Ave Date signed 5/25/44

G 17494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 17494 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 N Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 N Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Yetta Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years: 76 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Philip Katzoff
13. Birthplace: Russia

MOTHER
14. Maiden Name: Anna ?
15. Birthplace: Russia

16 (a) Informant: Benjamin Becker
(b) Address: 1508 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 24, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel Cem
Location: German Hill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 MAY 24 1944 Clayton Williams, M.D.

MEDICAL CERTIFICATION

2.30

20. DATE OF DEATH: May 24, 1944 at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to 5-23 1944, and that I last saw [illegible] alive on 5/23 1944.

Immediate cause of death: Senile cerebral arteriosclerosis — Duration: yrs

Due to: — Duration:

Due to: — Duration:

Other Conditions: Decubitus Ulcers — Duration: yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 7904 Rennert Rd Date signed 5/24/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G 17495
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1341 S.Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 S.Clinton St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Leo H.Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Margaret O'Brein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.18,1879

8. AGE: Years	Months	Days	If less than one day
65	4	3	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Electrican
11. Industry or business

FATHER
12. Name Not known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Joseph Lewis
(b) Address 1341 S.Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) MAY 24 1944 Hugh H. Williams M.D.
(Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1944, at 7:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to May 20, 1944 and that I last saw him alive on May 20, 1944

Immediate cause of death	Duration
Chronic asthmatic bronchitis	No. of Y
Chronic valvular heart disease	No. of y
Due to Arterio-sclerosis	years
Due to Myocardial insufficiency	2 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature I. B. Bronushas, M. D.
Address 3037 O'Donnell St Date signed 5-23-44 M.D.

G 17496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 17496 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Calaman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Md.

16 (a) Informant Wesley Calaman

(b) Address 1526 Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director C. A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) [illegible] for Williams, M.P. Registrar

MAY 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22- 1944, at 2.05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arterio-Sclerotic Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.

Date signed 5/22/44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G 17497
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Mc Henry Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Mc Henry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Nemzek

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1884

8. AGE: Years	Months	Days	If less than one day
60	2	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name Nemzek
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Elizabeth Nemzek
(b) Address 312 Normont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)
(c) Cemetery or crematory
Location Moreland Memorial Park

18 (a) Funeral director Harry H. Fritzke
(b) Address 4101 E. Monument Ave

19 (a) MAY 24 1944 (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22- 1944, at 10:45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5/22/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G 17498 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Un. H. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 666 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME adolfus J. Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lola Effie Holdingsworth | 6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) July 4 1872

8. AGE: Years 71 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Wm. J. Holmes
13. Birthplace S.C.

MOTHER 14. Maiden Name Nancy Ann Fowler
15. Birthplace S.C.

16 (a) Informant Hosp. record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory [illegible] PARK
Location 3901 [illegible] Rd

18 (a) Funeral director HARRY H. WITZKE
(b) Address 4101 Edmondson Ave

MAY 24 1944 (b) [illegible] Registrar

Huntington Hillman M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23-1944 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1944 to 5-23 1944 and that I last saw him alive on 5-23 1944.

Immediate cause of death Uremia — Duration

Due to Chr. Nephritis

Due to

Other Conditions Hypertension-Arteriosclerotic C.V.D.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Univ. Hosp. Date signed 5-23-44

17499 TANNERT V G 17499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Fulton Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Tannert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) APRIL 5, 1866

8. AGE: Years 78 | Months 1 | Days 17 | If less than one day —hr. —min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER 12. Name ERNEST TANNERT
13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Wingel
15. Birthplace Germany

16 (a) Informant Marie T. King
(b) Address 310 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn-Balto. Md.

18 (a) Funeral director F. B. Winpert & Son
(b) Address 1850 W. Balto. Street

MAY 24 1944 (Date rec'd by registrar) Hampton Williams M.D. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1944, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1944 to May 1944 and that I last saw h. alive on 5/21 1944

Immediate cause of death: Carcinoma of face
Due to: & Metastasis — Duration: —
Due to: — Duration: —
Other Conditions: — Duration: —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Chester J. Jablonski M. D.
Address 5217 Gwynnbrook Ave. Signed 5/22/44

G 17500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G 17500 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 Mc Culloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Mc. Culloh St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Hemton, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Abraham P. Robinson

FATHER 13. Birthplace Cumberland Md.

MOTHER 14. Maiden Name Eliza Thomas

MOTHER 15. Birthplace Md.

16 (a) Informant Emma Summerville

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Location Lakeland-Md.

18 (a) Funeral director Wm. Katie R. Williams

(b) Address 2220 N. Belvedere Av.

19 (a) (Date received by Registrar) MAY 24 1944 Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to May 20 1944 and that I last saw her alive on May 19 1944.

Immediate cause of death	Duration
Gastric ulcer	2
Due to Carcinoma of ovary	2
Due to	
Other Conditions Chronic myocarditis	2

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Walter Sherwyn M. D.
Address 201 N. Carey St. Date signed 5-23-44

G 17501

G 17501 11 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 N Carey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 N Carey
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Levi Scott

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name Anna Banton

MOTHER 15. Birthplace Va

16 (a) Informant Mrs. Anna Scott

(b) Address 234 N Carey Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Wilson

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Dolphin Ave Dr

19 (a) (Date received by Reg.) MAY 24 1944 Katie R. Williams (Signature of Funeral Director)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1944 at 9:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 5/1 1944 to 5/20 1944
and that I last saw h[illegible] alive on 5/20 1944

Immediate cause of death Carcinoma of Mamma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb 1944

Major findings of operation: Ca Mamma

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Jackson M.D.
[illegible] signed

G 17502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17502 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1663 Eighteen ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1663 Eighteen ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marcella Bentz

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife George H. Bentz
6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1862

8. AGE: Years	Months	Days	If less than one day
81	7	18	hr. min.

9. Birthplace Cincinnati Ohio (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Richard P. Bentz.
(b) Address 1663 Eighteen ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/44 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto Frederick Ave

18 (a) Funeral director John T. Cowgill
(b) Address 901 703 Hollins St

19 (a) Huntington Williams Registrar

MAY 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 12 M 20a

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944, to May 23 1944, and that I last saw he/she alive on May 22 1944.

Immediate cause of death	Duration
Mitral Regurgitation	7 D.
Decompensated	7 d.
Due to Arteriosclerosis	7 d.
Hypertension	7 d.
Due to Chronic Interstitial Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Stevens M. D.
Address 3878 Harford Rd Date signed 6-23-44

G 17503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G 17503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 W. 24th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) About 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. 24th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT BLACK.

3 (b) If veteran, name war ----- 3 (c) Social Security Account No. 254-03-7964.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1881

8. AGE: Years 63 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Edinbourgh, Scotland (Town, county, and state)

10. Usual Occupation Stone-cutter

11. Industry or business

FATHER 12. Name Thomas Black
13. Birthplace Fife, Scotland.

MOTHER 14. Maiden Name Ellen Fraser
15. Birthplace Scotland.

16 (a) Informant Mrs. Robert Gourlay (Sister)
(b) Address 114 W. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Ave.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) MAY 24 1944 [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1944 to 5-22- 1944, and that I last saw h[illegible] alive on 5-22- 1944

Immediate cause of death	Duration
Carcinoma of	
Due to Intestines	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: Yes

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Cross
Address 28 W 26th St Date signed 5-23-44

G 17504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 17504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3164 Elmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl L. Miller

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-7640

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife: Greta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1897.

8. AGE: Years 46 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business

FATHER
12. Name John Henry
13. Birthplace Balto.

MOTHER
14. Maiden Name Emma Burke
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Louise Miller
(b) Address 3164 Elmora Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1944 (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem.
Location Gryndon Ave.

18 (a) Funeral director Louis L. Heemann
(b) Address 32 S. Broadway
(c) Baltimore, Md.

MAY 24 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1944; at 11.35 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury?

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 5/22/44.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

FL - 6cd17505 / G 17505 / 186a — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Bachman or George Backman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3.1895

8. AGE: Years	Months	Days	If less than one day
48	11	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Herman Bachman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Marie ?
15. Birthplace Germany

16 (a) Informant Baltimore C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Rockwood Cem
Location Taylor Ave
18 (a) Funeral director John A Moran
(b) Address 3600 Baltimore St

19 (a) MAY 24 1944 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1944 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1944, to 5/21 1944, and that I last saw h[illegible] alive on 5/21 1944.

Immediate cause of death: Extra-dural hemorrhage; Left temporal fracture; Basal fracture

Duration

Due to: extensive to cerebellum; Arteriosclerosis; Acute & fresh meningeal hemorrhage

Other Conditions: Gen. arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/2
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence May 16, 1944 at 10 30 A.M.
(c) Where did injury occur? Place 6 Albemarle Sts (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? no
(e) Means of injury fell to pavement while drunk

23. Signature E. L. Sergeman
Address BCH Date signed M. 5 D. 23

VS 150

Approved Robert La Gratta M.D. 5/23/44

G 17506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G 17506

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 Montpilier St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1644 Montpilier St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Gibbons O'Neill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28 1864

8. AGE: Years 79 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Gibbons.

13. Birthplace Ireland

MOTHER 14. Maiden Name Katherine Bannon

15. Birthplace Ireland

16 (a) Informant James O'Neill

(b) Address 1644 Montpilier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director John G Motan

(b) Address 3000 E Baltimore St

19 MAY 24 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944 at 11 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19-1928 to 5-22-1944 and that I last saw her alive on 5-22-1944

Immediate cause of death Uremia — Duration 5 days

Due to Arteriosclerotic Cardio-renal disease — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature Geo. B. Sybert M. D.

Address 230 Stanford Rd Date signed 5-23-44

G 17507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 17507

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Ekelsom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife John Ekelsom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1859

8. AGE: Years	Months	Days	If less than one day
84	10	26	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name James Freebarough
13. Birthplace England

MOTHER
14. Maiden Name Jane Heidei
15. Birthplace England

16 (a) Informant Mr. John Ekelsom
(b) Address Severn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27-44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location

18 (a) Funeral director Charles P. Powell
(b) Address 427 E. Lanvale St.

19 MAY 24 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150 For O.R.L. Graham by Howard L. Weeden, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1944, to May 22 1944, and that I last saw her alive on May 22 1944.

Immediate cause of death	Duration
Cerebral accident - hemiplegia	1 day
Due to Hypertension	
Due to	
Other Conditions Fracture neck of femur, right.	24 days

(Include pregnancy within 3 months of death)
Date of operation 5-1-44
Major findings of operation: [redacted]
Fracture of femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident ?
(b) Date of occurrence 4-28-44 at A. M. M
(c) Where did injury occur? Severn Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fall while dancing
23. Signature Isabella Harrison M. D.
Address Church Home Hosp. Date signed 5-23

G 17508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2870 Kentucky
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2870 Kentucky (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie J. Bachmann

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Albert J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1882

8. AGE: Years 61 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. (Town, county and state)

10. Usual Occupation At Home.

11. Industry or business

FATHER 12. Name Edward L. Wolf

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Funk

15. Birthplace Balto

16 (a) Informant Howard Bachmann.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 26 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location #300 Block Pratt St. E. Side

18 (a) Funeral director Frank W. C. Dippold

(b) Address 2110 Eutaw Pl.

MAY 24 1944 Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1943 to May 23 1944.
and that I last saw h alive on May 22 1944.

Immediate cause of death Carcinoma of Lung
Metastasis
Duration 1 yr.

Due to

Due to

Other Conditions Bronchopneumonia 5 da.

(Include pregnancy within 3 months of death)

Date of operation Sept. 9, 1943.

Major findings of operation: Carcinoma of Lung Diagnosed

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Schorsch

Address 5939 Dr. Pleasant Date signed 5/25/44

17509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Saint Boltos. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 William Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin L. Feinburg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Mauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/15/1865

8. AGE: Years	Months	Days	If less than one day
59		6.	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Policeman.

11. Industry or business

FATHER — 12. Name	Conrad Linburg
FATHER — 13. Birthplace	Germany
MOTHER — 14. Maiden Name	Anna Mattes
MOTHER — 15. Birthplace	Germany.

16 (a) Informant Mr. Linburg

(b) Address 1217 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway

18 (a) Funeral director J. Fred Tayer

(b) Address 318 Light St.

MAY 24 1944 (Date rec'd by registrar) (b) Huntington Millington, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21-1944, at 10 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Fractured ribs - hemorrhage

Other Conditions Chronic Myocarditis Degeneration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 23-3

(a) Date of injury 5-21-44 at 10 P.M.

(b) Where did injury occur? Hanover & Cromwell Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Passenger - collision auto upset

23. Signature Howard Kleeberg M.D. Medical Examiner.

Date signed 5-22-44

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17510

Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton and Wilkins
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Brooklyn M
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 1895

8. AGE: Years	Months	Days	If less than one day
48	9	16	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Frank M Thompson
(b) Address 212 Franklin st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location Wash Blvd

18 (a) Funeral director Ambrose Tyson
(b) Address 414 N Franklintown Rd

19 (a) MAY 24 1944 Registrar
Haughton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1944, at 8:16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944 to 5/23 1944 and that I last saw her alive on 5/23 1944.

Immediate cause of death	Duration
Diabetic Coma	12 hrs
Due to	
Due to	
Other Conditions Umbilical hernia Hypertension C.V.D. (Include pregnancy within 3 months of death)	5 yrs.

Date of operation 5/20/44

Major findings of operation: umbilical hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J R Dwyer
Address 5 N Gay Baltimore Date

G 17511 HEALTH DEPARTMENT—CITY OF BALTIMORE G 17511

CERTIFICATE OF DEATH 92a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 873 Linden ave St., 21 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 13 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME Caroline Fisher

(a) Residence: No. 873 Linden ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Charles Fisher

6. DATE OF BIRTH (month, day, year) April 9 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	1	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. House Work

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carroll Co. Md

FATHER

13. NAME Johan Anderson

14. BIRTHPLACE (city or town) (State or country) Carroll Co

MOTHER

15. MAIDEN NAME Amanda Lowe

16. BIRTHPLACE (city or town) (State or country) Carroll Co

17. INFORMANT Stephen Fisher
(Address) 873 Linden ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. View Date May 25 1944

19. UNDERTAKER H. M. Snyder
(Address) Mt. Airy Md.

20. FILED 19

MAY 24 1944

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 22, 1944

22. I HEREBY CERTIFY, That I attended deceased from April 23 1944 to May 22 1944

I last saw h[illegible] alive on May 22 1944 Death is said to have occurred on the date stated above, at 6.50 p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coma and Stroke	May 22 1944

Other contributory causes of importance:

None

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) H. L. Peterson M. D.

(Address) 27 Hamilton Ter.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 17512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17512 Registered No.

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Wolfe & Eaton Ave
(c) Hospital or institution St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Md - Catonsville Manor
(If outside city or town limits, write RURAL and give town)
(d) Street No. Harford Ave & Engleside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Lorenz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Paul Lorenz
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1869

8. AGE: Years	Months	Days	If less than one day
75	4	18	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Michael Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Tuckenmiller
15. Birthplace "

16 (a) Informant Anna Marie Koontz
(b) Address Harford & Engleside Aves

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Robert C. Walters
(b) Address 1215 E. Monument Street

19 (a) (b) Huntington Indiana, Ind

MAY 24 1944

VS 180 Approved: Robert C. Walters Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1944 at 11:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1944 to 5-22 1944 and that I last saw h[illegible] alive on 5-22 1944.

Immediate cause of death Terminal Pneumonia — Duration

Due to Fracture of Left Hip

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-19-44

Major findings of operation: Fracture Left Hip; Application of Splint

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-15-44 at 9:15 P.M
(c) Where did injury occur? B2l to MD (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury Fall in her home

23. Signature W. H. McGrath M.D.
Address St. Agnes Hosp Date signed 5/27/44

MAY 23 1944

G 17513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 17513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Jonesway Pl
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Joseph A. Frejka

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Marie Frejka
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct. 28 1895

8. AGE: Years	Months	Days	If less than one day
48	6	21 23	hr. min.

9. Birthplace Bohemia
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business Grocery Business

MOTHER / FATHER

12. Name Joseph Frejka

13. Birthplace Bohemia

14. Maiden Name Anna Gremse

15. Birthplace Bohemia

16 (a) Informant Mrs. Joseph A. Frejka

(b) Address 3400 Jonesway . Balto 13.

17 (a) Burial (b) Date thereof 5/25/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Philadelphia Rd.

18 (a) Funeral director Charles E. Schimunek.

(b) Address 2601-03 E. Addison St.

(Undertaker or Embalmer) (b) Huntington Millinery, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1944 at 10.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944, to May 21 1944, and that I last saw him alive on May 21 1944

Immediate cause of death	Duration
Cardiac failure due to uremia	Sev. weeks
Due to Hypertensive Cardio-Vascular disease.	1 year +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Cook, Jr. M. D.

Address Mercy Hospital Date signed 5-21-44

G 17514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17514 Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution: Monument Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva B. Weidenhan

3 (b) If veteran, name war | 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	separated

6 (b) Name of husband or wife August Weidenhan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1871

8. AGE: Years	Months	Days	If less than one day
72	11	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Adam Kneucker
13. Birthplace Unknown
14. Maiden Name "
15. Birthplace

16 (a) Informant Marie A. Weidenhan- daughter
(b) Address 721 N. Lakewood Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison Street.

19 (a) (b) Thos. J. Hinkley M.D.

MAY 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24/44 19 at 12:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Cardiac failure — Duration

Due to Myocardial Impact: Coronary thrombosis

Due to Pulmonary thrombosis + infarct

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald E. Preston
Address Sinai Date signed 5/25/44

G 17518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G 17515
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md ✓ (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Mt. Holly St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-6372

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1885

8. AGE: Years 58 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Norton Lilly Steamship Co.

FATHER: 12. Name Samuel Thomas
13. Birthplace Balto, Md.

MOTHER: 14. Maiden Name Mary V. Robbins
15. Birthplace Balto, Md.

16 (a) Informant Mrs. Marie Thomas
(b) Address 517 mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto, Md.

18 (a) Funeral director Edmund F. Fleming
(b) Address 1426 Light St.

19 (a) MAY 24 1944 (b) Dayton Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1944, to May 22 1944, and that I last saw him alive on May 22 1944

Immediate cause of death: Bronchs - pneumonia — Duration 5 days

Due to

Due to

Other Conditions Ch. Bronchitis — 6 mos.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells, M. D.

Address 4100 Edmondson Ave Date signed 5/23/44

G 17516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered No. G 17516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY LOUIS WAGNER, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Barbara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1884

8. AGE: Years	Months	Days	If less than one day
59	7	6	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Louis Wagner
13. Birthplace Balto.

MOTHER
14. Maiden Name Elizabeth Hummel
15. Birthplace Balto.

16 (a) Informant Mrs. Anna B. Wagner
(b) Address 2025 N. Pulaski St.

17 (a) Burial (b) Date thereof 5/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 24 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 23, 1944, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944, to May 23 1944; and that I last saw h[illegible] alive on May 23 1944

Immediate cause of death	Duration
Cerebral hemorrhage	1 yr
Due to Chronic Nephritis	6 mos
Due to	
Other Conditions ~	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(g) Accident, suicide, or homicide ~
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 6277 Kenilworth Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B 1757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 6 17517

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)? If yes, name country

3 (a) FULL NAME LOUIS CLINTON St. CLAIR

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212 - 14 - 9225

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
male	white	Widower ~~married~~

6 (b) Name of husband or wife Frances M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1870

8. AGE: Years	Months	Days	If less than one day
74	0	21	hr. min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)
10. Usual Occupation Insurance Collector
11. Industry or business

FATHER
12. Name Louis St. Clair
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wingate
15. Birthplace Md.

16 (a) Informant Mrs. Frances Bordley
(b) Address 3300 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date received) MAY 24 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1944, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18, 1944, to May 23, 1944, and that I last saw him alive on May 23, 1944

Immediate cause of death Coronary Thrombosis — Duration Days

Due to

Due to

Other Conditions Hypertension and arteriosclerosis — 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice F. Shamer M. D.

Address 3300 W. North Ave Date signed 5/24/44

17518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 John St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE MacFARLAND

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 86			hr. min.

9. Birthplace --
(Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Richard MacFarland
13. Birthplace --

MOTHER
14. Maiden Name Elizabeth Jaggard
15. Birthplace --

16 (a) Informant Mrs. Wm. Lamdin
(b) Address 5202 Spring Lake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory
Location Elkton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944 to May 23 1944, and that I last saw her alive on May 17 1944.

Immediate cause of death	Duration
1) Arterio-Sclerotic Heart Disease	?
Due to	
Due to	
Other Conditions Generalized Sclerosis (Include pregnancy within 3 months of death)	?

Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts. Date signed 5/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

17519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 17519
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1041 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Peter Hampton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Color | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bab Bird Harrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace 1041 Edmondson Ave
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James B Hampton
13. Birthplace Johnsville Pa

MOTHER 14. Maiden Name Mary Bird
15. Birthplace Annapolis Co, Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 24 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 24 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

0372

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1944 to May 24 1944, and that I last saw h alive on May 23 1944

Immediate cause of death
Due to Stomach Cancer

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas H Wolff M. D.
Address 841 Park Ave Date signed 5/25/44

454513

G 17520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17520 Registered No. 4706

127 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Riderwood (If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Bishop
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: George L. Bishop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-69

8. AGE: Years 74 | Months 5 | Days 14 | If less than one day — hr. — min.

9. Birthplace D.C. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Arthur Chenowith
13. Birthplace Md.

MOTHER
14. Maiden Name Deborah ?
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Sater's Baptist Cem.
Location Baltimore Co., Md.

18 (a) Funeral director John Burns & Son
(b) Address Towson, Md.

19 (a) (Date received by registrar) (b) Registrar

MAY 25 1944 Hunt Valley, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to May 23 1944 and that I last saw h[illegible] alive on May 23 1944.

	Duration
Immediate cause of death: myocardial failure	30 mins
Due to: generalized peritonitis	+ days
Due to: ruptured gall bladder	? days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/17/44
Major findings of operation: Ruptured Gall Bladder - Gen. peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jessie A. Hayes, M.D.
Address Johns Hopkins Hosp. Date signed 5/23 M. D.

459806

G 17521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Ba. Co.
(c) City or town Shipley Heights (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolf Linde

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-6437

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-17-85

8. AGE: Years	Months	Days	If less than one day
59 58		7	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

MOTHER / FATHER

12. Name John Linde

13. Birthplace Germany

14. Maiden Name Eula Anna Beiß

15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5-26-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Geo. F. Schwab

(b) Address 201 Frederick Avenue

19 (a) (b) Register No.
(Date received by registrar)

MAY 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to May 24 1944 and that I last saw him alive on May 24th 44

Immediate cause of death Respiratory Failure — Duration

Due to Squamous Cell Carcinoma

Due to Lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen

Address JHH Date signed 5-24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 of 17522 — G 17522 — 43D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N. Madeira St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N. Madeira ct (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josefa Houtnik

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles Houtnik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1863

8. AGE: Years 80 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name Joseph Olk
13. Birthplace Bohemia

MOTHER — 14. Maiden Name Josefine Soutrodg
15. Birthplace Bohemia

16 (a) Informant Beatrice Benedict
(b) Address 912 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brockdorf
(b) Address 900 N. Chester St

19 (a) (b) (Date rec'd by registrar) MAY 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 7:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to May 22 1944, and that I last saw her alive on May 22 1944.

Immediate cause of death Coronary thrombosis — Duration 1 day
Due to Myocarditis
Due to Hypertension & Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodor Kleiner M. D.
Address 2623 E. Monument Date signed 5/24/44

G 17523

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 17523
Registered No.

CERTIFICATE OF DEATH 13a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 School St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 School St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1893

8. AGE: Years 50 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Alexander Barnes
13. Birthplace Md

MOTHER 14. Maiden Name Mary E. Greenwell
15. Birthplace Md

16 (a) Informant Elizabeth Glenn
(b) Address 1825 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-44 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem.
Location Md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Presstman St

19 (a) (Registrar) (b) Huntington Williams, M.D. Registrar

MAY 25 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1944 to 5/23 1944 and that I last saw h— alive on 5/23 1944

Immediate cause of death Hypertensive Cardio Renal, Vascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

2 Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. F. Hatcher

Address 1225 Park Ave Date signed 5/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17524

54335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121a

Registered No. G 17524

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 547 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Gertrude Herbst

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-22-92

8. AGE: Years 51 | Months 10 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Samuel Cornish
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Brannicke
15. Birthplace Md.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus cem.
Location Md.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Prestman St

19 (Signature) MAY 25 1944 Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to May 23 1944 and that I last saw h[illegible] alive on May 23 1944

Duration
Immediate cause of death Uremia
Due to arteriolonephrosclerosis
Due to Hypertensive cardio-vascular disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.....

23. Signature John R. Birmingham M. D.
Address 7 N. Howard Date Signed 5/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 17525
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Diggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1942

8. AGE: Years 1 | Months 2/11 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Diggins
13. Birthplace Franklin Pa

MOTHER
14. Maiden Name Mary A. Lewis
15. Birthplace Pa

16 (a) Informant Mrs Mary Diggins
(b) Address 1417 Gilmor Court

17 (a) Burial (b) Date thereof 5-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto Md.

18 (a) Funeral director Mrs Frances A. Hemmings
(b) Address 547 W. Biddle St.

MAY 25 1944 (Signature) Thaddeus Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 5-30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1944 to May 23 1944 and that I last saw h[illegible] alive on May 23 1944

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thaddeus Williams, M.D.
Address Provident Hospital Date signed 5/25/44

17526 HANTMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 17526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dudland Rd.
(c) Hospital or institution: WBGH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Hantman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Isaac

13. Birthplace Russia

MOTHER 14. Maiden Name Mary

15. Birthplace Russia

16 (a) Informant Dr Harry Hantman

(b) Address 3649 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY 25 1944 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Rt 40 & Hamilton Blvd

18 (a) Funeral director Jas. Levin Inc

(b) Address 1439 E. Baltimore St

MAY 25 1944 (Date filed by registrar)

(b) Signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1944, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1944, to 5/23 1944, and that I last saw him alive on 5/23 1944.

Immediate cause of death Myocardial infarction — Duration 2 days

Due to Coronary Thrombosis

Due to

Other Conditions Pulmonary congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M. D.

Address WBGH Date signed 5/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G 17527

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 N. Saratoga
(c) Hospital or institution: 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1315 N Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Branch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. m

6 (b) Name of ~~husband~~ or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16- 83

8. AGE: Years 60 | Months 10 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Laurel Md (town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Thomas Boston
13. Birthplace Md

MOTHER
14. Maiden Name Mary Braddox
15. Birthplace Md

16 (a) Informant Loretta Smaggott
(b) Address 1315 N. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. A. Co Md
18 (a) Funeral director Sam'l H. Chase & Son
(b) Address 638 N Gilmor St
19 (a) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to May 22 1944 and that I last saw h alive on May 22 1944

Immediate cause of death Strangulated Hernia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. Hebeler
Address 1715 Eutaw Pl Date signed May 26 1944

G 17528 452072 — Grave # 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

✓ G 17528 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 S. Exeter (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 - ? - 76

8. AGE: Years	Months	Days	If less than one day
67	11	-	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Stone
13. Birthplace Russia

MOTHER 14. Maiden Name Dora Sussman
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAY 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 25 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1944 to May 14 1944 and that I last saw living on May 14 1944

Immediate cause of death — Duration

Respiratory Failure

Due to

Due to Bronchiectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Sonnen M. D.
Address J. Hopkins Hospital Date signed 5-16

G 17529
TN. 88107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G 17529
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3346 Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Flamer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Flamer (D
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Gunner (D
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director C. Vernon Lynnam
(b) Address 461 Pk. Hgts.

19 MAY 25 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1944 at 6.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1944, to 5-22 1944, and that I last saw h^ alive on 5-22 1944.

Immediate cause of death	Duration
Decompensation	?
Due to Hypertensive cardio vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathue M.D.
Address B.C.H. Date signed 5/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B 17530 — 1645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 — G 17530 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or institution: 2 yrs. 5 mos. 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Hard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Annie Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Winfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26-1880

8. AGE: Years 63 | Months 10 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Mollock
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Wills
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. PK.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) ... (Date rec'd by Registrar) MAY 25 1944 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21- 1944 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 5/21 1944 and that I last saw her alive on 5/21 1944

Immediate cause of death: Bronchopneumonia — Duration: 5

Due to

Due to

Other Conditions: H.C.V.D.; acute nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seligman M.D.
Address BCH Date signed 5/23

G 17531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G 17531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Carrollton Ave. Balto. 17, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Katherine Watts~~. Katherine Hattie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 27, 1893

8. AGE: Years 50 51 yrs. Months 79 Days 3 27 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Watts
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Brown
15. Birthplace Maryland

16 (a) Informant Katie Watts
(b) Address 1121 Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-44 (mo.) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Bradley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 44, at 1:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 19 44, to May 25 19 44, and that I last saw her alive on May 23 19 44

Immediate cause of death Respiratory Failure — Duration ? 6 months

Due to Metastasis of breast cancer to lung

Due to Breast cancer

Other Conditions Left hemiplegia probably due to metastasis to brain. (Include pregnancy within 3 months of death)

Date of operation July 1943

Major findings of operation: Provident Hospital. Cancer of breast

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Ellsworth Cook Jr. M. D.

Address Mercy Hospital Date signed 5-25-44

G 17532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

118

Registered No. G 17532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Savage

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 114-12-3347

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Margaret Savage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1912

8. AGE: Years 32 | Months - | Days 7 | If less than one day hr. min.

9. Birthplace Accomac Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Savage
13. Birthplace Va

MOTHER
14. Maiden Name Bertha Allen
15. Birthplace Va

16 (a) Informant Margaret Savage
(b) Address 423 N. Caroline St.

17 (a) Burial (b) Date thereof 5-27-44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elwood Wilson
(b) Address 1600 Bank St

19 (a) (b) Registrar
(Date received by Local Registrar)
MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 8:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute gastritis, pulmonary edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 23 1944

G 17533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

✓ G-17533 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 843 Pierce St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Walker

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-03-8015

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Helen Mealey (Common law wife) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16 1900

8. AGE: Years	Months	Days	If less than one day
43	5	5	hr. min.

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Maryland Sanitary Co.

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Helen Mealey
(b) Address 843 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) MAY 25 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1944, at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944, to 5/21 1944, and that I last saw him alive on 5/20 1944.

Immediate cause of death: Carcinoma of Stomach with ulceration + perforation causing abscess of liver.

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Abscess of liver

Major findings of operation: 5/19/44

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hosp. Date signed 5/21/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 17534

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Dora Theresa Valentine

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1871

8. AGE: Years	Months	Days	If less than one day
73	4	7	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Francis J. Valentine
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary R. Podesti
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Catherine Valentine
(b) Address 1120 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Miars and Son
(b) Address 805 N. Calvert Street

19 (a) Huntington Williams, M.D. Registrar

Date Received MAY 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944 at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1940. to May 23, 1944. and that I last saw h-- alive on May 23 1944.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 hour
Due to Coronary Sclerosis	4 years
Due to Generalized Arteriosclerosis	4 years.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Zimmerman
Address 1 W. Read Date signed 5/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 17535
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 Long 17
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Long st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Addam (Addam)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife James Addam
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1870

8. AGE: Years	Months	Days	If less than one day
54	1	26	hr. min.

9. Birthplace Amelia Co. Va.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Pleasant Mead
13. Birthplace Va.

MOTHER
14. Maiden Name Amelia Mead
15. Birthplace Va.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 5-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location AA Co. Md.
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
19 MAY 25 1944 (Signature) Huntington Williams, M.D.
(Local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944 6:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to May 22 1944.
and that I last saw h alive on 1944.

Immediate cause of death Myocarditis — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address
Date signed 5-25-44 M. D.

G 17536
TN. 87740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17536
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Boone Dewey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Horace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1901

8. AGE: Years	Months	Days	If less than one day
42	5	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Giles
13. Birthplace Maryland

MOTHER
14. Maiden Name Estelle (?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Alexander St.

19 (a) (Date received by registrar) (b) Registrar
MAY 25 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1944 at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1944, to 5-22 1944, and that I last saw h. or alive on 5-22 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathna M. D.
Address B, C. H. Date signed 5/25/44

17537 G 17537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County Pinellas
(c) City or town St. Petersburg
(If outside city limits, give township)
(d) Street No. [redacted] (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernst Maron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) [redacted]

8. AGE: Years	Months	Days	If less than one day
68	2	18	hr. min.

9. Birthplace Switzerland (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Julius Maron
13. Birthplace Switzerland

MOTHER
14. Maiden Name Ayla Wirz (Wirz)
15. Birthplace Switzerland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27/44 (month) (day) (year)
(c) Cemetery or crematory White Marsh Cemetery
Location Montgomery Co. Md.

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1700 Eutaw Pl.

19 (a) 5/25/44 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944 at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to 5/24 1944 and that I last saw h[illegible]live on May 24 1944

Immediate cause of death Uremia — Duration 4 days

Due to Nephrosclerosis

Due to Metastatic carcinoma probably primary in Prostate — Duration 9 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Dickson M. D.
Address Hopkins Hosp. Date signed 5/25/44

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

17538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17538 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) all life (?)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Ridgely (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lyon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Thomas F. Lyon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 11 - 1869

8. AGE: Years	Months	Days	If less than one day
74 73	8	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name David Phillips
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cooper
15. Birthplace Md.

16 (a) Informant Norman Lyon (Son)
(b) Address 1134 Ridgely

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Cem
Location Hampden & Miller Sts.

18 (a) Funeral director John E. Oliver & Son
(b) Address 2435 Huntington Ave.

MAY 25 1944 (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24/1944, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1943 to 5/24 1944 and that I last saw h. alive on 5/24 1944

Immediate cause of death: Resp failure — Duration
Due to: Cerebral accident
Due to: Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Clif Ravenel, Jr. M.D.
Address University Hosp Date signed 5/24/44

G 17539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 13B

G 17539

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2607 E. Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2607 E. Jefferson St. (Or other location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA MEIER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gustave Meier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1908

8. AGE: Years 35 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Matuszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Tefika ?
15. Birthplace Poland

16 (a) Informant Mr. Gustave Meier
(b) Address 2607 E. Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Cape Arundel County

18 (a) Funeral director John A. Grebliunas Jr
(b) Address 423 S. Paca St.

MAY 25 1944 (Date rec'd by Local Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 05 1944 to May 23 1944 and that I last saw her alive on May 20 1944

Immediate cause of death: Cardiac Thrombosis — Duration 6 days

Due to Hypertension — 10 days

Due to

Other Conditions Pachymeningitis Hemorrhagica — Chron

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Hawkins M.D.
Address 1 E Read St Date signed May 25 1944

17540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

G 17540
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Watson, St,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Watson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME, Mary A. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. ? 1865

8. AGE: Years 5-8 | Months 7 | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Solman Powell
13. Birthplace N.C.

MOTHER
14. Maiden Name Millie Spivy
15. Birthplace N.C.

16 (a) Informant Rivia Moore
(b) Address 1615 Waldo St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26 (month) (day) 1944 (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

MAY 25 1944 (b) Thos. Taylor Williams Mgr

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21-1944 to 5-21-1944, and that I last saw he alive on 5-21-1941.

Immediate cause of death: Carcinoma of breast

Due to

Due to

Other Conditions Metastatic carcinoma (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature Ben Purcell M. D.
Address 1422 E. Chase Date signed 5-25-44

G 17541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G 17541 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hosp 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~Balto~~ Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 35 Custom House Ave (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 27, 1906

8. AGE: Years 37 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Brooklyn N.Y. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business Transplayed

FATHER: 12. Name Robert Stevens

13. Birthplace N.Y.

MOTHER: 14. Maiden Name Margaret Boyle

15. Birthplace N.Y.

16 (a) Informant Robert Stevens

(b) Address 114 Pioneer St Brooklyn

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof MAY 25 44 (month) (day) (year)

(c) Cemetery or crematory St Johns Cemetery Brooklyn N.Y.

Location Brooklyn N.Y.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul Street

19 (a) (Signature of registrar) (b) (Registrar)

MAY 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1944, to 5-25 1944, and that I last saw h.im alive on 5-24 1944.

Immediate cause of death Cirrhosis of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. C. Z. Grush M. D.

Address Mercy Hosp. Date signed 5-25-44

G 17542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17542 Registered No. 1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3241 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3241 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline H. Schilpp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1850

8. AGE: Years 93 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name John Maisenhelder
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Germany

16 (a) Informant F C Schilpp
(b) Address 2830 Alameda Blvd

17 (a) Burial (b) Date thereof 5-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director John C Moser
(b) Address 3600 E Baltimore St

19 (a) (b)
(Date received by registrar)

MAY 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944 at 5P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 10 1944 to 5/20 1944, and that I last saw him alive on 5/23/1944.

Immediate cause of death	Duration
Arteriosclerosis Edema	4 hrs
Due to Arteriosclerosis Old Age	
Due to	
Other Conditions Chronic Myocarditis Chronic Lobar Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh D. Hyder M. D.
Address 5373 E Baltimore St Date signed 5/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G 17543

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs. 13 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS ARTHUR FOLEY (Note: Was discharged 3/3/44 this hosp.)

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife: Bessie Carey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/19/94

8. AGE: Years 50 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Utica, New York (Town, county, and state)

10. Usual Occupation Thompson's Restaurant- Cook

11. Industry or business

FATHER
12. Name William Foley
13. Birthplace Co. Cork, Ireland

MOTHER
14. Maiden Name Bridgett Eyan
15. Birthplace Co. Cork, Ireland

16 (a) Informant Records, U.S. Marine Hosp.
(b) Address Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Frederick Road

18 (a) Funeral director A. Lee Ader
(b) Address 1644 Gay St.

19 MAY 25 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1944, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21, 1944, to May 21, 1944, and that I last saw him alive on May 21, 1944

Immediate cause of death Adenocarcinoma of the cecum — Duration Approx. 9 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Bran, M. D.
Address Baltimore, Md. Date signed 5/23/44

VS 150

Va-1

File 17544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G 17544

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Darling St -
(c) Hospital or institution: St Joseph's Hospital. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 S Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alexander Krasinski (Aleksander Krasinski)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Felikra Krasinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 65 | Months | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

MOTHER / FATHER
12. Name Aleksander Krasinski
13. Birthplace Poland
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs Aleksander Krasinski
(b) Address 418 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director Mrs. Mary Weber
(b) Address 401 S. Chester Street

19 (a) (b) Washington Williams

MAY 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1944 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-18 1944 to 5-24 1944 and that I last saw h/ alive on 5-24-1944

Immediate cause of death: Cardiac Failure Chronic Myocarditis -
Due to Arterial - Emphysema
Due to Chronic Bronchitis
Other Conditions Hypertrophied Prostate
(Include pregnancy within 3 months of death)

Duration: Several years

Date of operation 5-22-44
Major findings of operation: Hypertrophied prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L Vanni, M. D.
Address Dr. Jos. Hosp Date signed 5-27-44

G 17545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 17545 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 S.COLLINGTON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S.COLLINGTON AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BLUM

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 31 1889

8. AGE: Years	Months	Days	If less than one day
54	9	24	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name MICHAEL BLUM
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY JARMAN
15. Birthplace GERMANY

16 (a) Informant MARY SCHEPF (SISTER)
(b) Address 227 S.COLLINGTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 27/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler U.C.
(b) Address 403 S.WOLFE ST.

MAY 25 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 24 1944, at 8/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to May 24 1944, and that I last saw h[illegible] alive on May 24 1944.

Immediate cause of death	Duration
Acute Bronchio-Pneumonia	3 days
Due to Acute Bronchitis.	?
Due to	
Other Conditions Epilepsy Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Jennings M. D.
Address 2002 E Fayette Date signed 5/25/44

G 17546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 17546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 N. Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Belnord Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Petras

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2863

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clara Petras
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 22-1890

8. AGE: Years	Months	Days	If less than one day
54	4	29	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Julian B Fritz

FATHER
12. Name Frank Petras
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Miller
15. Birthplace Baltimore

16 (a) Informant Clara Petras
(b) Address 217 N Belnord Ave

17 (a) Burial (b) Date thereof 5/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (Date) MAY 25 1944 Huntington, Pennsylvania

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 8 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratton M.D.
Medical Examiner.
Date signed May 23 1944

G 17547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

G 17547
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Yolanda Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Yolanda Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A Campbell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm H Campbell
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug 22 1898

8. AGE: Years 45 | Months 9 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home
11. Industry or business At Home

FATHER
12. Name Harry Engel
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Knorr
15. Birthplace Germany

16 (a) Informant Wm H Campbell
(b) Address 3810 Yolanda Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2004 Orleans St

19 (a) Date received MAY 25 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943, to May 24 1944, and that I last saw h[illegible] alive on May 15 1944.

Immediate cause of death: Embolism from intramural thrombus (Probably) — Duration: Immediate
Due to: Auricular Fibrillation — Duration: years
Due to: Rheumatic Heart Disease Mitral Insufficiency — Duration: years
Other Conditions: Toxic Adenoma of Thyroid Diabetes mellitus — Duration: Ser. months
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert W. Garis, M. D.
Address 1014 St. Paul St. Date signed 5/25/44

G 17548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17548 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2ey

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 N. Gay St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Minnie Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Henry Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1894

8. AGE: Years 50 | Months - | Days 23 | If less than one day hr. min.

9. Birthplace Orange Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Charles Brown

13. Birthplace Orange Va.

14. Maiden Name Delia Smith

15. Birthplace Orange Va

16 (a) Informant Minnie Kenney (Daughter)
(b) Address 1219 N. Gay St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 5/26/44 (month) (day) (year)
(c) Cemetery or crematory Burial
Location Orange, Va.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 142 Jefferson St

19 (a) (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MAY 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1944, to May 22 1944, and that I last saw h[illegible] alive on May 22 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 week
Due to Myocarditis	3 weeks
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] L Lefkovitz M.D.
Address 622 N. Broadway Date signed 5/23/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17549 Registered No.

JO #83157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 hrs. 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Covington St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-8274

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Arthur Jones

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1895

8. AGE: Years 48 | Months -7- | Days 18 | If less than one day hr. min.

9. Birthplace Balto., Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Thomas H. Trowers
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda Moon
15. Birthplace Balto., Maryland

16 (a) Informant Records, Baltimore City Hosp. and Cemetery Lists
(b) Address 4940 Eastern Ave. 1619 Covington St. - Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1944

(c) Cemetery or crematory Moreland Park Location Md.

18 (a) Funeral director A. Howard Ervin
(b) Address 1400 - S. Charles St. Balto. 30, Md.

19 (a) (Date rec'd) (b) Registrar

MAY 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1944, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1944 to 5/23 1944. and that I last saw h[er] alive on 5/23 1944.

Immediate cause of death: Cerebral Accident with Lacerations

Due to

Due to

Other Conditions

Duration: 2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathews M.D.
Address B.C.H. Date signed 5/24/44

17550

84327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. C-17550

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 9

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1055 N. Fairmount Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Burris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1913

8. AGE: Years	Months	Days	If less than one day
30	2	28	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Louis Burris

13. Birthplace N. C.

MOTHER

14. Maiden Name Martha Jane Lovick

15. Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1944 (month) (day) (year)

(c) Cemetery or crematory

Location Wilmington, N. C.

18 (a) Funeral director Mrs. Jas. W. Holland

(b) Address 1631 Dock St. Wilmington, N. C.

MAY 26 1944

Filed by Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1944 at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1943 to 5/22 1944 and that I last saw him alive on 5/22 1944

Immediate cause of death	Duration
Pulmonary TBC	7
Due to	
Due to	
Other Conditions Syphilis & Arteriosclerosis	2 wk

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sergeant M.D.

Address BCH Date signed 5/22

G 17551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832 ✓

G 17551 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA. Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S. New York St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Leonard Nardone

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-07-2452

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Grazia Nardone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1888

8. AGE: Years 55 56 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Colle St. Vito Italy (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Flavio Nardone
13. Birthplace Italy

MOTHER
14. Maiden Name Donata D'Aiuto
15. Birthplace Italy

16 (a) Informant Grazia Nardone (Wife)
(b) Address 301 Newkirk St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27/44 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Mt. Carmel Rd.

18 (a) Funeral director Frank Della Noce
(b) Address 52. N. Morley St.

19 (a) MAY 26 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1944, at 10.50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McNally M.D. Medical Examiner.
Date signed 5/25/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

VG 17552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

VG 17552 Registered No. 520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St 9a 9

(c) Hospital or institution: St. Jos. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Lebesville # 8 Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 909 Windsor Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) **FULL NAME** William Hillger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day: hr. min.

9. Birthplace New Orleans La, (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Charles L. Hillger

13. Birthplace ?

MOTHER

14. Maiden Name Emily ?

15. Birthplace ?

16 (a) Informant Mr. Louis Hillger

(b) Address 909 Windsor Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick Ave, Balto

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd

19 (a) (b) Registrar

MAY 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25-1944, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16-1944 to 5-25-1944, and that I last saw him alive on 5-25-1944.

Immediate cause of death	Duration
Peritonitis	
Due to Postoperative (nephrectomy)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-16-44

Major findings of operation: Carcinoma of Rt. Kidney

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank L. Vanni, M. D.

Address St. Jos. Hosp. Date signed 5-25-44

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 17553

CERTIFICATE OF DEATH

130 G 17553

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 N. Redwood St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yr. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

If U. S. Veteran specify WAR .....

2. FULL NAME Nello Celestino

(a) Residence: No. 758 Redwood St., 4-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) June 1908

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	36	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Halifax N C

FATHER

13. NAME Edward Alsbrs

14. BIRTHPLACE (city or town) (State or country) N. C

MOTHER

15. MAIDEN NAME Hala Willoughby

16. BIRTHPLACE (city or town) (State or country) N C

17. INFORMANT Dela Williams
(Address) 758 N. Redwood

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Date May 28 1944

19. UNDERTAKER Sam'l H Chase & Son
(Address) 638 N. Gilmor St

20. FILED ..... 19.....
Registrar.

Information should be carefully supplied. State CAUSE OF DEATH in plain terms. OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 24, 1944

22. I HEREBY CERTIFY, That I attended deceased from Apr. 24 1944 to May 24 1944

I last saw h alive on May 24 1944 Death is said to have occurred on the date stated above, at 6:10 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary edema due to myocarditis	2 Days
Other contributory causes of importance: Pulmonary Tuberculosis ?	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify .....

(Signed) Wm. LeRoy Perry M. D.

(Address) 1420 E. Chase

MAY 26 1944 Huntington Williams M.D.

G 17554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G 17554 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 E. Eager st.
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 E. Eager st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar V. Fleece

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 12th 1898

8. AGE: Years 46 | Months 4 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Berkley Springs W. Va (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER
12. Name William F. Fleece
13. Birthplace W. Va.

MOTHER
14. Maiden Name Sarah E. Covell
15. Birthplace Williamsport Md

16 (a) Informant Miss Mary Virginia Phenozigo
(b) Address 816 E. Eager st.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/26/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenway
Location Hagerstown Md.

18 (a) Funeral director William Cook Inc.
(b) Address 121 E. Paul st.

19 (a) (b) Huntington Williams, M.D. Registrar

MAY 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25th 1944 2 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1944, to 5/24 1944, and that I last saw h[illegible] alive on 5/24 1944.

Immediate cause of death (a) Ch Pulmonary TB — Duration

Due to (b) —

Due to (c) —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Hometown M. D.
Address 733 Angelica St Date signed 5/26/44

G 17555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17555 Registered No. 112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Nancy) Mary E. Whiting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 11, 1867

8. AGE: Years	Months	Days	If less than one day
2	2	14	hr. min.

9. Birthplace HUNTINGTON, PA.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ROBERT Whiting
13. Birthplace N.Y.

MOTHER
14. Maiden Name MARY McKelvey
15. Birthplace OHIO

16 (a) Informant Robert Whiting
(b) Address 2510 York Rd Dundalk

17 (a) Remort (Burial, cremation, or removal) (b) Date thereof 5/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Bedford
Location Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1327 St. Paul St

19 (a) MAY 26 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 19 44, at 6 00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asthma, Bronchial.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNulty M.D. Medical Examiner.
Date signed 5/25/44

VS 151

17556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

G 17556
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 Norfolk Ave.
(c) Hospital or institution:
15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 1/2 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Norfolk Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? 7 1/2 Yrs. years

3 (a) FULL NAME LEO SCHIFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hedy Schiff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1892

8. AGE: Years	Months	Days	If less than one day
51	6	28	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Manager Brush Factory
11. Industry or business

FATHER
12. Name Solomon Schiff.
13. Birthplace Germany.

MOTHER
14. Maiden Name Minna Blum.
15. Birthplace Germany.

16 (a) Informant Mrs. Hedy Schiff.
(b) Address 3900 Norfolk Ave.

17 (a) Burial (b) Date thereof 5/26/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) [illegible] (b) [illegible] M.D.
MAY 26 1944
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th. 1944, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 19 to 5/26 19 44
and that I last saw h[illegible] alive on 5/26 19 44

Immediate cause of death

	Duration
Carcinoma of Lung	3 mos?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of lung
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Meem B Kirsh M. D.
Address 2904 Reisterstown Rd Signed 5/26/44

17557 BROOKS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17557 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd & Dutton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Kate Augusta W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1866

8. AGE: Years 77 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Not employed recently

FATHER 12. Name Deceased
13. Birthplace

MOTHER 14. Maiden Name Deceased
15. Birthplace

16 (a) Informant Mrs Elsie Thal (THAL)
(b) Address 724 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore Md.

18 (a) Funeral director Harry H. Whitsell
(b) Address 4101 Edmondson ave

19 MAY 26 1944 Washington Millinery Mfg

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944, at 2:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24 1944 to 5-24 1944, and that I last saw h. i. alive on 5-24 1944

Immediate cause of death Respiration Ceased — Duration

Due to Cardiac Decompensation

Due to Degenerative Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Rinehart M. D.
Address University Hosp. Date signed 5-29-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ca 13558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

$17558 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Foster ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Foster ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Kalendek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Felix Kalendek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Barylski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Zielinski
15. Birthplace Poland

16 (a) Informant Mrs. Joseph Felix Kalendek
(b) Address 3109 Foster ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore Catholic

18 (a) Funeral director Mrs. Mary Debely
(b) Address 401 S. Chester Street

MAY 26 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to May 24 1944.
I last saw him alive on May 23 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 1 y.
Due to:
Due to:
Other Conditions: Diabetes
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
[illegible] Patterson Park [illegible]

G 17559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G 17559 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 N Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 N. Wolfe St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Matthews
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jackson Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10 1879

8. AGE: Years 64 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Patman
13. Birthplace Va.

MOTHER
14. Maiden Name Adeline Seay
15. Birthplace Va.

16 (a) Informant Bettie Gough
(b) Address 932 N. Wolfe St.

17 (a) Removal (b) Date thereof May 26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Farmville Virginia

18 (a) Funeral director Thos. Robt A. Elliott & Dyt.
(b) Address 1129 N Caroline St.

19 (a) (b) Registrar

MAY 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1944, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15-1944 to 5-24-1944, and that I last saw he alive on 5-23-1944.

Immediate cause of death Carcinoma Liver

	Duration
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rev Purcell M. D.
Address 1422 E. Clare Date signed 5-25-44

G 17560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Argyle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James I. Nash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Hattie Nash
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1891

8. AGE: Years	Months	Days	If less than one day
52	9	29	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Brown Nash
13. Birthplace Virginia

MOTHER
14. Maiden Name Nancy Banks
15. Birthplace Virginia

16 (a) Informant Anna Nash
(b) Address 1129 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Wm. H. Kelso
(b) Address 1303 Pressstman St

19 (a) (Date received by registrar) (b)
MAY 26 1944 Huntington Millington M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1944, at 9.50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 5/25/44

G 17561 ✓ G 17561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

Dr. 87549

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Waddy Nicholas or Nicholas Waddy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1875

8. AGE: Years 68 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Waddy
13. Birthplace Va.

MOTHER
14. Maiden Name Sally Johnson
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Leg. H. Kelson
(b) Address 1303 Presstman

19 (a) (b)
(Signature of local registrar)

MAY 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1944, at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1944 to 5/22 1944, and that I last saw h[illegible] alive on 5/22 1944

Immediate cause of death Hemorrhage from ruptured esophageal varix — Duration 24 h.

Antecedent

Due to Cirrhosis of liver, alcoholic

Due to

Other Conditions 1+ CVD & hemiplegia left; Anes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: [illegible] yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.

Address 13 CH Date signed 5/24

17562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G 17562

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 S. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Weisenborn, Nicholas (Nicholas George Weisenborn)

3 (b) If veteran, name war --

3 (c) Social Security Account No. 218-09-5682

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret Weisenborn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1870

8. AGE: Years	Months	Days	If less than one day
73	11	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Continental Can Co.

FATHER
12. Name Frank Weisenborn
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy E.
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Weisenborn
(b) Address 528 S. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1944 at 9:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1944, to 5/24 1944, and that I last saw h.i.s. alive on 5/24 1944.

Immediate cause of death respiratory and circulatory failure

Due to ? coronary or renal-cardiac disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/22

Major findings of operation: Benign prostatic hypertrophy

of autopsy: almost left kidney small

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving S. Sherbow, M. D.
Address Sinai Hospital Date signed 5/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 17563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Fenton Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Addie E. Whittington (Addie Elizabeth Whittington)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Edward Whittington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1871

8. AGE: Years	Months	Days	If less than one day
72	5	8	hr. min.

9. Birthplace: Anne Arundel Co., Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Wm. G. Owings
13. Birthplace: Md.

MOTHER
14. Maiden Name: Miranda Ward
15. Birthplace: Md.

16 (a) Informant: Mr. Royal Edward Whittington
(b) Address: 1832 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by Local Registrar: MAY 26 1944 (b) Huntington Williams, M.D. Registrar

JHS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1944, at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1944, to 5-22 1944, and that I last saw her alive on 5-22 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions: Fracture of L. femur. (Include pregnancy within 3 months of death)	

Date of operation 5-5-44
Major findings of operation: Aggravation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 5-4-44 at 4 P. M
(c) Where did injury occur? 1833 Clifton Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No.
(e) Means of injury Injured a step at home + fell.

23. Signature John Edward Whittington Jr.
Address Med. Exam. Asst. Date signed 5-22-44 M. D.

For H. B. McNally by Howard J. Worrell, M. D.

G 17564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Dunford ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta C. Roth

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John B.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1880

8. AGE: Years: 64 | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John F. Heese
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Krarme
15. Birthplace: Pa.

16 (a) Informant: Mr. John F. Roth, son
(b) Address: 109 Birchwood Rd., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 26 1944 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-24- 1944, at 5-45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractures Cervical Vertebrae

Due to:

Other Conditions: Multiple Lacerations, abrasions & bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/24/44 at 28/4 5.15 P.M.
(b) Where did injury occur? Frederick Rd. nr Mellon Hill Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger auto. struck Telegraph pole

23. Signature: Howard J. Huldeen M.D. Medical Examiner.
Date signed 5/25/44

VS 151

17565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 17565

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE GEORGE McCALL

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Warren L. McCall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1872

8. AGE: Years	Months	Days	If less than one day
72	3	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wadsworth Nash
13. Birthplace Va.

MOTHER
14. Maiden Name Mary F. Miller
15. Birthplace Del.

16 (a) Informant Mr. Warren L. McCall
(b) Address 4001 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 26 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1944 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1943 to May 24 1944, and that I last saw h[illegible] alive on May 24 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	5 dys
Due to Renal Arteriosclerosis	5 yrs
Due to Arterial Hypertension	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James B. Aterhurst M. D.
Address 4612 Park Heights Date signed 5-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 17566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 6 17566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: the H. University H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Parkview
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yen Chin (CHINYEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Chinese

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) abt 1878

8. AGE: 66 Years | Months – | Days – | If less than one day: hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Worked for Re

11. Industry or business Chinese Assn

FATHER
12. Name not known
13. Birthplace China

MOTHER
14. Maiden Name not known
15. Birthplace China

16 (a) Informant Chin You Hong (cousin)
(b) Address 322 Parkview

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-26-44 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Woodlawn

18 (a) Funeral director Slavin Mem Co.
(b) Address 1015 Pinkney

19 (a) [illegible] Washington Williams, M.D.
Registrar

MAY 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1944 at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1944 to 5-24 1944 and that I last saw him alive on 5-24 1944

Immediate cause of death Pulmonary Edema, Parental

Duration

Due to Hypertensive-arteriosclerotic cardiovascular disease

Due to Chronic Nephritis

Due to Heart failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Shipley M. D.

Address University Hosp. Date signed 5-24-44

17567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47E

Registered No. G 17567

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1603 N. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leah Bishow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Levy
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Howard Bishow
(b) Address 1603 N Payson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-26-44 (month) (day) (year)
(c) Cemetery or crematory Lemon Zedeck
Location Garrison Blvd Rd

18 (a) Funeral director Jack Levy Inc
(b) Address 1435 E Belvedere

19 MAY 26 1944 (b) [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1944, at 6:10 AM

21. I certify that death occured on the date above stated; that I attended deceased from 4/26/1944, to 5/26/1944, and that I last saw h[illegible] alive on 5/26/1944

Immediate cause of death Resp Failure — Duration
Due to Carcinoma of the Pleura
Due to Pleura
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp Date signed 5/26 D.

G 17568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G 17568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN MOLLOCK

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-6391

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Mollock
13. Birthplace Caroline Co Md

MOTHER
14. Maiden Name Annie Brown
15. Birthplace Dorchester Co Md

16 (a) Informant Carl Mollock
(b) Address 1233 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1944 (month) (day) (year)

(c) Cemetery or crematory Lakeville Md
Location

18 (a) Funeral director Robert E Williams
(b) Address 15-15 Mt Elderry Rd

19 (Date received by Registrar) MAY 29 1944 Huntingtown Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1944 19 , at 3:10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-23-44 at 3:10 P. M. 2/3
(b) Where did injury occur? Harbor - Foot of Conn St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found drowned

23. Signature H. Z. Wallenstein M.D. Medical Examiner.
Date signed 5-23-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G 17569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert F. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1895

8. AGE: Years	Months	Days	If less than one day
49	4	10	hr. min.

9. Birthplace Tolbert Co., Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Tue Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Maryetta Smith
(b) Address 1100 Division St.

17 (a) Burial (b) Date thereof 5/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mt. Francis A. Hemsley
(b) Address 597 W. Biddle St.

19 (a) (b)
(Date received by Registrar)

MAY 26 1944

VS-150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 24, 1944 19 , at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30-43 19 , to 5-24 1944, and that I last saw h alive on 5-16 19 44

Immediate cause of death	Duration
Carcinoma Parotid gland	9 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwood Jones M. D.

Address 5-5-4 Dolphin St. Date signed 5-25-44

17570 RABER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 50

G 17570 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 S Potomac St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lettie M. Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bertram Raber
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Mar 15 1875

8. AGE: Years	Months	Days	If less than one day
69	2	10	..... hr. ..... min.

9. Birthplace Hanover Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name John M. Hamm
13. Birthplace Pa

MOTHER
14. Maiden Name Caroline Walderstroff
15. Birthplace Pa

16 (a) Informant Mrs Helen Benning
(b) Address 717 S Potomac St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 29 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Hanover Pa

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 E. Orleans St

19 MAY 29 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1944 at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1944 to 5-25 1944 and that I last saw h.e alive on 5-25 1944

Immediate cause of death Coronary Thrombosis

Duration

Due to
Due to
Other Conditions Cellulitis of Leg
(Include pregnancy within 3 months of death)
Date of operation 5-24-24
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. Mackenzie M. D.
Address 1213 Light St Date signed 5-25-1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN 86407 86407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480 Registered No. G 17571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Months 5 - 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29th, 1906

8. AGE: Years 37 | Months 5 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Richardson (D
13. Birthplace Va.

MOTHER
14. Maiden Name Melvin Bartly (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) ... (b) Date thereof ... (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (c) MAY 26 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1944, at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1944 to 5-20 1944, and that I last saw her alive on 5-20 1944.

Immediate cause of death Carcinoma of uterus
Due to with metastases
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald B Webb M. D.
Address Balto City Hosp Date signed 5-20-44

VS 150

10976

G 17572 ✓ G 17572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 4309 E Rasp Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 6
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4309 Raspe Ave (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No) If yes, name country

3 (a) FULL NAME Laura Virginia Allentuch

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Geo. W. Allentuch (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan 2 - 1880

8. AGE: Years 63 | Months 6 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name George Thomas
13. Birthplace Baltimore

MOTHER: 14. Maiden Name Amelia Jessop
15. Birthplace Baltimore

16 (a) Informant Ethel Bergner
(b) Address 4309 Raspe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Cem
Location Taylor Ave

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 N. North Ave

19 (a) MAY 26 1944 (Date received by registrar) Huntington Hitchcock

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 44 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19__, to May 23 19 44 and that I last saw h[illegible] alive on May 23 1944.

Immediate cause of death	Duration
Coronary Disease	3 yrs
Due to Myocardial Insufficiency	1 day
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Bergner M. D.
Address 1 W. Oreilla Date signed 5/24/44

G 17573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17573

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5203 Edmondson ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5203 Edmondson ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William F. McMahon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4. 1865

8. AGE: Years 79 Months 2 Days 21 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Ret. Clerk

MOTHER / FATHER

12. Name Wm. F. McMahon

13. Birthplace Balto. Md.

14. Maiden Name Catherine L. Parks

15. Birthplace Balto. Md.

16 (a) Informant John F. McMahon

(b) Address 5203 Edmondson ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28. 44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St.

19 (a) (By) Huntington Williams Registrar

(b) MAY 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to May 25 1944 and that I last saw h[illegible] alive on May 24 1944

Immediate cause of death: Cardiac Thrombosis — Duration: 3 days

Due to Arterio Sclerosis — 2 yrs

Due to Hypertension — 3 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature [illegible] Howe Jones M.D.

Address 1 E Read St Date signed 5/26/44

G 17574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G 17574 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E. North Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles V. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1902

8. AGE: Years 42 | Months -3- | Days 16 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Bell (d)
15. Birthplace: Maryland

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-1944 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: Flynn & Fleming
(b) Address: [illegible] Light St.

19 (a) MAY 26 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1944, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1944, to 5-24 1944, and that I last saw h[illegible] alive on 5-24 1944.

Immediate cause of death: Carcinoma of Cervix — Duration: 1

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Donald Botelho M. D.
Address: Balto City Hosp. Date signed 5-25-44

17575 454750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 17575

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 St Matthew (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME E M. Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Viola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 [illegible] 98

8. AGE: Years 45 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Tobe Allen
13. Birthplace Ga

MOTHER 14. Maiden Name May Frances Clark
15. Birthplace Ga

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Elberton, Ga.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bransley

19 (a) MAY 27 1944 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 150 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1944, to May 25 1944, and that I last saw him alive on May 25 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Date signed 5-25-44

MC 17576 454682

PEIRCE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17576 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pky
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Peirce Enry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Esther Belt

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 8-22-65

8. AGE: Years 78 | Months 9 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William H. Peirce Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Georgia Browne
15. Birthplace ~~JOHNS HOPKINS HOSPITAL~~ N.H.

16 (a) Informant Records
(b) Address J.H.H.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address 11 Cullen Harford 25 Huntington Williams, Md.

(b) Date received MAY 27 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944 to May 25 1944 and that I last saw him alive on May 25 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Spencer M.D.
Address Johns Hopkins Hosp. Date signed 5-25-44

G 17577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17577 Registered No. 1630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5609 Woodbrook ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. ~~Daniel H~~ Hutchins (Mary K.)

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Daniel H. Hutchins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1892

8. AGE: Years	Months	Days	If less than one day
52	3	24	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fred Nebel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Powers
15. Birthplace Ireland

16 (a) Informant Daniel H. Hutchins
(b) Address 5609 Woodbrook

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 N. Paca St

MAY 27 1944 (Date received by Registrar) (Signature) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25- 1944, at 3 30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy - hospital thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ Probably homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bi Chloride of Mercury Poisoning

Due to

Other Conditions Asthenia, obstruction. Ulceration of mucosa of stomach.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 5-26-44

READ CAREFULLY. PRINT ALL ANSWERS WITH UNFADING INK. Every item of information should be carefully summed. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17578
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~(436 E. 20th St.)~~
(c) Hospital or institution:
Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 E. 26th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Thos. D. McGraw Sr~~ Thomas Gerald McGraw Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced:~~ Married

6 (b) Name of ~~husband or~~ wife Susan M. McGraw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2nd 1890

8. AGE: Years 53 | Months 11 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Ex Salesman

11. Industry or business National Brewing Co.

FATHER
12. Name Thomas McGraw
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary Ann Price
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs June M. Deming
(b) Address 734 E. 21st St.

17 (a) Burial (b) Date thereof 5/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 27 1944 [illegible] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26/1944, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1944 to 5/26 1944 and that I last saw him alive on 5/26 1944

Immediate cause of death Coronary Thrombosis — Duration 2 wks.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thos. McGraw Jr. M.D.
Address Bon Secours Hosp. Date signed 5/26/44

Funeral will not be held until this certificate is filed. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 17579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and accurately recorded. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Glenarm Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Glenarm Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME: Louisa Hentz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1883

8. AGE: Years	Months	Days	If less than one day
60	7	26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Reinhold Hentz
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Bartel
15. Birthplace Germany

16 (a) Informant Mrs. Marie B. Franke
(b) Address 4502 Glenarm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Schwartzs
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

MAY 27 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1943 to 5-23 1944 and that I last saw h 2 alive on 5-23 1944.

Immediate cause of death: Myocarditis
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions: Chronic Interstitial nephritis

Duration
?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Michael J. Horstkotte M. D.
Address 1401 Bolton St. Date signed 5-26-44

17580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C 17580

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 Elsinor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Elsinor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES C. CARVER

3 (b) If veteran, name war: nohe
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marian Gould Carver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/1884

8. AGE: Years 60 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business Chas. F. Eareckson & Co.

FATHER
12. Name Francis T. Carver
13. Birthplace Havre de Grace

MOTHER
14. Maiden Name Virginia Fairchild
15. Birthplace Balto.

16 (a) Informant Mrs. Marian G. Carver
(b) Address 2801 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 27 1944 (Date received by Registrar) Washington Williams M.D. (Reg'r)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1944, at 7:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 15 1944, to May 25 1944, and that I last saw him alive on May 25 1944.

Immediate cause of death	Duration
Acute Heart Dilatation	1 Day
Due to Myocarditis	6 weeks
Due to Pre Supposed Family History of Heart Disease,	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johnson J. Green M. D.
Address 5276 Park Heights Av Date signed May 26

VS 150

17581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 17581

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3730 Ellerslie Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Ellerslie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERMAN A. SCHENDEL

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No. 705-05-5125

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa M. Schendel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/1878

8. AGE: Years 65 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business B. & O. R. R.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Rosa M. Schendel
(b) Address 3730 Ellerslie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed MAY 27 1944 (b) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apl 10. 1944 to May 25. 1944 and that I last saw living alive on May. 25. 1944.

Immediate cause of death	Duration
Acute Cardiac Dilatation.	1 hrs.
Due to Chronic Myocarditis.	2 yrs.
Other Condition Hypertension	"

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake, M. D.
Address Med. Arts Bldg. Date signed 5/26/44

VS 150

454125 G 17582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17582 Registered No. 1176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roy Kuge

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 11-1-88

8. AGE: Years	Months	Days	If less than one day
55	6	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Will Kuge
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Louis
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/44 (month) (day) (year)
(c) Cemetery or crematory Whitehall
Location Maryland

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill ave.

19 (a) MAY 27 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 44 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 19 44 to May 25 19 44 and that I last saw h[illegible] alive on May 25 19 44.

Immediate cause of death	Duration
Cerebral Embolism	2 Days
Due to Generalized Peritonitis	3 Days
Due to Duodenal Ulcer	15 years
Other Conditions Jaundice	3 Days

(Include pregnancy within 3 months of death)
Date of operation May 17th
Major findings of operation: Duodenal Ulcer - Partial Gastrectomy
of autopsy: Blow-out of Duodenal Stump

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Wood Jr. M. D.
Address Johns Hopkins Hospital Date signed 5/26

G 17583
JL - 88176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G-17583

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Green

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1921

8. AGE: Years	Months	Days	If less than one day
22	6 7	15 17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Guy Green
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Watkins
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director C. Halstead
(b) Address 2121 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Hunting Town, Millsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1944, at 7:24 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1944, to 5-26 1944, and that I last saw h[illegible] alive on 5-26 1944.

Immediate cause of death Pulmonary tuberculosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathre M. D.
Address 8 P St. Date signed 5-26-44

MAY 27 1944

17584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G 17584

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D&A. Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 270 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA Cora Needles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Oswell Needles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1898

8. AGE: Years 45 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Vincent Handy
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ct.
15. Birthplace Va.

16 (a) Informant Joan Louise Needles
(b) Address 2072 Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27th 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem'y
Location D. A. Co. Md.

18 (a) Funeral director Bedsworth Maples & Knight
(b) Address 727 Desoto St.

19 (~~MAY 27 1944~~) ~~Hughes Williams M.D.~~ REGISTRAR

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1944, at 1:50 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio - vascular renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.

Date signed 5/25/44

G 17585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 17585 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby James Rose

3 (b) If veteran, name war: NO
(c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 26 1944

8. AGE: Years | Months: 2 | Days: 11 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name NORMAN P. ROSE
13. Birthplace KENTUCKY

MOTHER
14. Maiden Name BEVERLY McVEY KENTU
15. Birthplace KENTUCKY

16 (a) Informant RECORDS OF
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 29/44 (month) (day) (year)
(c) Cemetery or crematory BARBOURVILLE CEM.
Location PERMON KENTUCKY

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAY 27 1944 (b) Huntington Williams, M.D. (registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944 at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to May 26 1944 and that I last saw him alive on May 26 1944.

Immediate cause of death Resp. failure — Duration

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellis Feer M. D.
Address 601 N. Broadway Date signed 5-26-44

G 17586 — BALTIMORE CITY HEALTH DEPARTMENT — G 17586 Registered No.

CERTIFICATE OF DEATH 13a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Paca

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/16/1873

8. AGE: Years 71 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Hartford Co. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER
12. Name Howe
13. Birthplace Hartford Co. Md

MOTHER
14. Maiden Name
15. Birthplace —

16 (a) Informant Joseph Ellis (nephew)
(b) Address 508 N. Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (Date received by registrar) MAY 27 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25/44, at 12:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh P. Marshall, M.D. Medical Examiner.
Date signed 5/25/44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 17587 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Mount St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	married

6 (b) Name of husband or wife Mary Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1875

8. AGE: Years	Months	Days	If less than one day
68	10	26	hr. min.

9. Birthplace St. Charles, S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Frank Wilson
13. Birthplace St. Charles S. C.

MOTHER 14. Maiden Name Emma Wilson
15. Birthplace

16 (a) Informant Mary Wilson
(b) Address 704 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MAY 27 1944 Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23 1944, at 11:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944, to 5/23 1944, and that I last saw h. alive on 5/21 1944.

Immediate cause of death
Carcinoma of Stomach
a Metastasis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:

of autopsy:

Duration
14 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Jackson M. D.
Address 600 N. Gilmor Date signed 5/27/44

G 17588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17588 Registered No. 1176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 186 N. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edwardo Kreba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-13-06

8. AGE: Years 38 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Kreba
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Keller
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5/30/44 (Burial, cremation, or removal) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave

18 (a) Funeral director John A. Nolan
(b) Address 3010 E. Baltimore St

19 (a) (Date received by Registrar) MAY 27 1944 Registrar Huntington Williams M.D.

NB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944 at 7 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944 to May 26 1944 and that I last saw he alive on May 26 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Acute hepatitis - cause unknown 1 wk	
? Epidemic jaundice	
Due to Intoxication	
Other Conditions Bleeding duodenal ulcer ? erosion hemorrhage	10 hrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Gerber M. D.
Address JHH Date signed 5-26

G 17589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nora D. Stroemer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Allen Stroemer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16, 1895

8. AGE: Years	Months	Days	If less than one day
49	4	9	hr. min.

9. Birthplace Lynchburg Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Elliot
13. Birthplace Lynchburg Va

MOTHER
14. Maiden Name Sally Burns
15. Birthplace Va

16 (a) Informant Allen Stroemer (Husband)
(b) Address 602 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29/44 (month) (day) (year)
(c) Cemetery Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) MAY 27 1944 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1944 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to 5/25 1944 and that I last saw h[illegible] alive on 5/25 1944

Immediate cause of death: Walvular Stenosis / Cardiac decompensation — Duration: 8 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Lethell F. Swormstedt M. D.
Address 1076 S East Ave Date signed 5/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 17590

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1743 E Gorsuch a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 T
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 E Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Dougherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Widow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1881

8. AGE: Years 63 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Long Island N.Y. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Industrial Alcohol Co employed

FATHER
12. Name Thomas Dougherty
13. Birthplace N.Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Mrs Anna M Burgan
(b) Address 2185 E Federal st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave

18 (a) Funeral director William M Marack
(b) Address 715 Light St

19 (a) MAY 27 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 9:5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1936, to May 25 1944, and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Smith M. D.
Address 1922 E North Ave Date signed 5/26/44

H. M. Williams M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17591
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 N Calvert St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Frances Griffin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1860 1860

8. AGE: Years 83 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Drug maker

11. Industry or business

FATHER — 12. Name James Thomas Griffith
13. Birthplace Pennsylvania.

MOTHER — 14. Maiden Name Miss Polly Logan
15. Birthplace Baltimore, Md

16 (a) Informant Miss Polly Griffin
(b) Address 3314 N Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fredericksburg

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1426 Eutaw Place

MAY 27 1944 (Date received by local registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944 to May 25 1944, and that I last saw her alive on May 25 1944.

Immediate cause of death	Duration
Cerebral - Vascular Accident	
Due to Hypertensive Heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hurd Powell Jr. M. D.
Address Union Memorial Hosp Date signed 5/26/44

G 17592

G 17592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156 B

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Homestead St., Balto 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Margaret M — Sadler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Robert L. Sadler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1899

8. AGE: Years 44 | Months 7 8 | Days 24 6 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore City, Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank L. Annen
13. Birthplace Balto.

MOTHER
14. Maiden Name Eleanor V. Moffitt
15. Birthplace Balto

16 (a) Informant Deceased
(b) Address .

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 29 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director Mack F. Dippel's Sons
(b) Address 321 Cathedral St.
19 MAY 27 1944 (Date rec'd by registrar) Washington Millicent, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to May 26 1944, and that I last saw h.e alive on May 26 1944

	Duration
Immediate cause of death: Acute pulmonary edema	2 hrs
Due to: Acute heart failure	2 3/4 hrs
Due to:	
Other Conditions: Myoma uteri	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation May 26, 1944
Major findings of operation: Myoma uteri
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Glenn D. Grove M. D.
Address Union Memorial Hosp. Date signed 5/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125B

G 17593 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 Remington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/ /1904

8. AGE: Years 40 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER
12. Name Scott J. Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Katie ?
15. Birthplace Md

16 (a) Informant George Jackson
(b) Address 2841 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 29 44 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Catonsville Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1441 Jefferson St

MAY 27 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944 to May 26 1944, and that I last saw h[illegible] alive on May 26 1944

Immediate cause of death Acute Hepatitis — Duration

Due to

Due to

Other Conditions Acute Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Hypertrophy of Liver & Kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Bamford M. D.
Address [illegible] Date signed 5/30/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. C 17594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution:
Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Monkton (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Tillman

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 44

8. AGE: Years	Months	Days	If less than one day
			9 hr. 53 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Premature baby.
11. Industry or business

FATHER
12. Name Charles William Tillman
13. Birthplace Baltimore Co.

MOTHER
14. Maiden Name Cora Lee Simon
15. Birthplace Virginia

16 (a) Informant Charles Wm Tillman
(b) Address Monkton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Jarlath
Location My Lady's Manor, Balto Co. Md.

18 (a) Funeral director John Burns Long
(b) Address Towson, Md.

19 (a) Date received by local registrar MAY 27 1944 (b) Registrar Huntington Millwood, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 7:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to May 26 1944 and that I last saw h. alive on May 26 1944.

Immediate cause of death Prematurity — (Birthwt. - 3lbs, 13 oz.)
Due to —
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —
23. Signature L. Ray G. Tilt M.D.
Address Univ. Hospital Date signed 5/26/44

17595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G 17595

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2884 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2884 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald W. McCrabe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1943

8. AGE: Years | Months: 7 | Days: 21 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dennis A. McCrabe
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden Name Hilda Hiteshew
15. Birthplace Howard County, Md.

16 (a) Informant Mrs Hilda McCrabe
(b) Address 2884 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 200 N. Longwood

19 (a) Date rec'd by local registrar MAY 27 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to May 25 1944, and that I last saw h[illegible] alive on May 14 1944.

Immediate cause of death	Duration
Congenital Hydrocephalus	
Due to	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin H. Lemmon M. D.
Address 4209 Hud Ave Date signed 5/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G 17596 Registered No. 9-17596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carl Miller

3 (b) If veteran, name war NO
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12. 1896

8. AGE: Years 47 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name Ludwig Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Marguerite Lisstz
15. Birthplace Germany

16 (a) Informant Palmer
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29. 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location City
Funeral director Mr. & Mrs. John W. Teufel & Son

MAY 28 1944 [illegible] Registrar

19 (a) (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944, to 5/25 1944, and that I last saw h.e.m. alive on 5/25 1944.

Immediate cause of death: Carcinoma of pancreas — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/17

Major findings of operation: See above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Kemp, MD M. D.
Address Univ. Hospital Date signed 5/26

G 17597 ✓ G 17597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 777

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK M. SHUMATE

3 (b) If veteran, name war

3 (c) Social Security Account No. 230-07-9027

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Matilda Shumate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12th 1903

8. AGE: Years	Months	Days	If less than one day
41	3	14	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business Steam Fitter

FATHER
12. Name Chas. M. Shumate
13. Birthplace Va

MOTHER
14. Maiden Name Katie Ragsdale
15. Birthplace Va

16 (a) Informant Matilda Shumate
(b) Address 528 W. Mulberry St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/28/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Danville
Location Va

18 (a) Funeral director William Cook Inc
(b) Address 121 E. Saratoga St

19 MAY 28 1944 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944 at 9P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

Immediate cause of death	Duration
Chronic alcoholism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Wollammaker M.D. Medical Examiner.
Date signed 5-26-44

VS 6

G 17598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G 17598 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 E. Monument St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Alston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race b | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James Alston | 6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan. 6 th 1895

8. AGE: Years 49 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Chester S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Adam Blake
13. Birthplace Chester S. C.

MOTHER 14. Maiden Name Eliza Thompson
15. Birthplace Chester S. C.

16 (a) Informant James Alston
(b) Address 1009 E. monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Chester S. C.

18 (a) Funeral director Byron & Magnis W. Hughes
(b) Address 721 Eisquith St

MAY 28 1944 (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 19 44 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 43 to Jan 15 19 44, and that I last saw h[im] alive on Jan 15 19 44

Immediate cause of death Cerebral Hemmorrhage — Duration 5/24/44

Due to Arteria Sclerosis & Alcohol

Due to Hypertension

Other Conditions Chronic Nephritis, Late Latent Lues

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J. Young M. D.
Address 1124 E Monument St Date signed 5/27/44

C. J. Zubrinski M.D. per H. Z. Wallenmeyer M.D.

G 17599 ✓ G 17599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 Dolphin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1890

8. AGE: Years	Months	Days	If less than one day
53	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business

MOTHER / FATHER
12. Name unknown
13. Birthplace
MOTHER
14. Maiden Name Sophie
15. Birthplace Va

16 (a) Informant Mrs. Helena Davis
(b) Address 528 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Mt. ~~Calvary~~
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

MAY 28 1944 (Date rec'd by registrar) Huntington Mill...

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1944 to May 26 1944 and that I last saw h[im] alive on May 13 1944.

Immediate cause of death Chron. Myocarditis — Duration Indef.

Due to Not known

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Keller M. D.
Address 332 W. Monument Date signed 5/26/44

4547347600 BALTIMORE CITY HEALTH DEPARTMENT V G 17600

CERTIFICATE OF DEATH 160a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Jordan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Veronica Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-44

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Roy Carter
13. Birthplace Md

MOTHER 14. Maiden Name Evelyn Mindes
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Registrar) (b) Registrar

MAY 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 910 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944, to May 25 1944, and that I last saw her alive on May 25 1944

Immediate cause of death: Hemorrhage (81)
Due to: Intracranial Hemorrhage
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Bartungh M. D.
Address Johns Hopkins Date signed 5-25-44

G 17601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X G 17600 Registered No. 1228

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural Granite (Balto. Co.) (If outside city or town limits, write RURAL and give town)
(d) Street No. Granite (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William J. Peach. SR.

3 (b) If veteran, name war.

3 (c) Social Security Account No. 212-18-2345

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife Agnes. Peach (deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-1869.

8. AGE: Years 74 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Attorney at Law.

11. Industry or business

FATHER
12. Name Charles Peach.
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Kelly.
15. Birthplace Ireland.

16 (a) Informant Vernice B Peach.
(b) Address 515 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director C. Howard Strong
(b) Address 3207 W. North Ave.

(c) MAY 28 1944 (d) Registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 5:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1944, to May 25 1944, and that I last saw him alive on May 25 1944.

Immediate cause of death Cardio-respiratory failure — Duration 5 days

Due to Prolonged and difficult post-operative course following — 11 days

Due to Surgical operation for intestinal obstruction.

Other Conditions None.
(Include pregnancy within 3 months of death)

Date of operation May 14, 1944

Major findings of operation: Obstruction of small intestine, mechanical, Strike Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Patrick C. Shelan Jr. M. D.

Address Mercy Hospital Date signed 5/27/44

G 17602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G 17602 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Dillon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Dillon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katarzyna Sas.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race | 6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Joseph Sas-
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1867
8. AGE: Years 77 | Months | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Tillie Poszluna
(b) Address 2824 Hudson St
17 (a) Br (Burial, cremation, or removal) (b) Date thereof 5-29-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk ave.
18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.
19 (a) (Date rec'd by registrar) (b)

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944 at 8:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1943 to May 26 1944 and that I last saw h-r alive on May 26 1944
Immediate cause of death Myocardial Insufficiency — Duration 14 days
Due to Chronic Myocarditis — 2 yrs.
Due to
Other Conditions Aortic Regurgitation — 2 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John V. Szydlich M.D.
Address 1802 Eastern Date signed 5/26/44

G 17603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17603 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4918 Curtis Ave. (26)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (26)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4918 Curtis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife (nee Potts) Julia A. Murphy
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1873

8. AGE: Years	Months	Days	If less than one day
70	8	11	12 hr. min.

9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation Retired Electrician
11. Industry or business Own Electrical Business

FATHER
12. Name Wm. Murphy
13. Birthplace Don't Know

MOTHER
14. Maiden Name Don't Know
15. Birthplace Don't know

16 (a) Informant Mrs. Julia A. Murphy (Wife)
(b) Address 4918 Curtis Ave. Balto. 26, Md.

17 (a) Burial – (b) Date thereof May 28, 1944
(Burial, cremation, or removal) (Month, day, year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. G. Co. Md.

18 (a) Funeral director Ed. J. Young Funeral Home
(b) Address 1400 S. Charles St. Balto. 30, Md.

19 (a) MAY 28 1944 (b)
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1944, at 10:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1943 to May 24 1944 and that I last saw him alive on May 24 1944

Immediate cause of death
Arteriosclerosis
Due to Insufficient Blood
Due to Senility

Duration 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. Murphy Co
Address 1340 E. Chase Date signed May 28/44

(over)

G 17604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17604 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 135 - W. Randall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (30)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 W. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob S. Fries

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1847

8. AGE: Years	Months	Days	If less than one day
96	8	4	hr. min.

9. Birthplace Winchester, Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business At Home

FATHER
12. Name Samuel Fries
13. Birthplace Va.

MOTHER
14. Maiden Name Don't Know
15. Birthplace Va.

16 (a) Informant Charles W. Fries (Son)
(b) Address 135 W. Randall St. Bala. 3 gmd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Park
Location Glen Burnie, Md.

18 (a) Funeral director A. Howard Brown
(b) Address 1400 N. Charles St. Balto. 39, Md.

MAY 28 1944
VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1944 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1940 to 5-26 1944 and that I last saw h[illegible] alive on 5-26 1944

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	4 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature A. Ballod M. D.
Address 707 E. Fort Ave. Date signed 5-27-44

G 17605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46B

G 17605 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 S. Payson Stad
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 S. Payson St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Tilton Rigby

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Augusta Rigby
6 (c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.) Dec. 1 1878
8. AGE: Years 65 66 | Months 65 | Days 25 | If less than one day: hr. min.
9. Birthplace Balto. County Md. (Town, county and state)
10. Usual Occupation Huckster
11. Industry or business Self

FATHER
12. Name Henry Rigby
13. Birthplace Balto. County Md.

MOTHER
14. Maiden Name Amanda Bowman
15. Birthplace Balto. County Md.

16 (a) Informant Augusta Rigby
(b) Address 332 S. Payson St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.
18 (a) Funeral director Joseph Schwab
(b) Address 2101 Fredrick Ave.

MAY 28 1944 (b) [illegible] Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 2:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to May 26 1944, and that I last saw him alive on May 26 1944.

Immediate cause of death: Carcinoma of stomach — Duration: 1 year
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Kerman M. D.
Address 1934 Wilkens Av Date signed 5/26/44

G 17606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

G 17606

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Lake Drive
Riviera Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Apts.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME BLANCHE OETTINGER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1874

8. AGE: Years 69 Months 10 Days 14 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Oettinger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Jeannette Weil,
15. Birthplace Germany.

16 (a) Informant Mr. Edwin Blum,
(b) Address Riviera Apts.

17 (a) Burial (b) Date thereof 5/29/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Sinai Memorial Chapel
(b) Address 1902 Eutaw Place.

19 (a) MAY 28 1944 Hamilton M. Miller, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27th. 1944 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1939, to May 27 1944, and that I last saw h[illegible] alive on May 26 1944.

Immediate cause of death	Duration
Carcinomatosis	7 mos
Due to Carcinoma of rectum	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of Rectum April 1939
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed 5/27/44

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 17607 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 N 40th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N 40th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion DuShane Howard Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: ~~Oct 3 1859~~

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 3 1859

8. AGE: Years 84 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Alex. DuShane
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Eliz. Marion Duke
15. Birthplace Calvert Co Md

16 (a) Informant Hartman K Harrison
(b) Address 1000 Poplar Hill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W Jenkins Sons
(b) Address 2nd & Cullok Orchard Sts

MAY 28 1944 (Date rec'd by registrar)

(b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 8A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1944 to May 27 1944, and that I last saw h[illegible] alive on May 26 1944.

Immediate cause of death: Sudden Heart failure — Duration 2 Hours

Due to Acute Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Gibson Porter M. D.
Address 4622 Roland Ave Date signed 5/27/44

G 17608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17608 Registered No. 12262

*PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 Park ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Park ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Naturalized

3 (a) FULL NAME Frank James Mallett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Mary Long
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Jan 17 1858
8. AGE: Years 86 | Months 4 | Days 10 | If less than one day ... hr. ... min.
9. Birthplace: Kings Lynn England (Town, county, and state)
10. Usual Occupation: Priest
11. Industry or business:

FATHER: 12. Name John Mallett
13. Birthplace Kings Lynn England
MOTHER: 14. Maiden Name Elizabeth Brown
15. Birthplace Kings Lynn England

16 (a) Informant: Rev Reginald Mallett
(b) Address: 709 Park ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 29 1944 (month) (day) (year)
(c) Cemetery or crematory Chapel Hill Cem.
Location Chapel Hill N.C

18 (a) Funeral director: Henry W Jenkins & Sons
(b) Address: McCulloh & Eichard Sts.

MAY 29 1944 (Date received) (b) Thomas Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to May 27 1944, and that I last saw him alive on May 26 1944

Immediate cause of death: Small intestinal obstruction — Duration: 4 days

Due to: Adhesions in right lower quadrant of abdomen

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: —

of autopsy: Gangrenous small intestine

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature: John Tilden Howard M. D.
Address 12 E Eager St. Date signed May 27 1944

G 17609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 17609 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 Wilkens ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Frances Pilkenton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1944

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name James Pilkenton
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Kathryn Helgo
15. Birthplace Baltimore, Maryland

16 (a) Informant James Pilkenton
(b) Address 2239 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 917 Greenmount Ave
(c)

MAY 28 1944 (Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to May 26 1944 and that I last saw h.l.[illegible] alive on May 26 1944

Immediate cause of death	Duration
Immediate cause of death Respiratory Failure.	
Due to Dehydration Acidosis.	
Due to Prematurity	
Other Conditions Physiological Jaundice	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul R. Riggle
Address Mercy Hospital Date signed M. 5 D. 26/44

Dr Ashman
1924 W North Ave

G 17610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V83a

G 17610 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 Ridgehill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Ridgehill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Albecker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1885

8. AGE: Years 58 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name August Albecker
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Graf
15. Birthplace Germany

16 (a) Informant Mr John Graf
(b) Address 525 Oakland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29-1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore

18 (a) Funeral director Francis Cook Eyfer
(b) Address 1600 W North Ave

(a) (Local registrar) (b)

MAY 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to May 27 1944 and that I last saw h[illegible] alive on May 27 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 2½ hrs.
Due to: Hypertension — Duration unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Ashman M D
Address 1924 W North Ave Date signed 5/27/44

G 17611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 17611 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 May Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1886

8. AGE: Years 58 | Months - | Days 22 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Magellus Abrams
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Elizabeth Lewis
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs. Edna Cox
(b) Address 715 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Hall
(b) Address 1631 North Fulton Ave.

19 (a) (Date received by registrar) (b) Registrar

MAY 28 1944

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944 to May 27 1944 and that I last saw h alive on May 22 1944

Immediate cause of death: Hypertensive Cardio Vascular-Renal disease

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Bayne M. D.

Address Provident Hospital Date signed 5/31/44

G 17612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G 17612 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Wilson

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Smithville, Dorchester Co. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Wm Wilson
13. Birthplace Smithville, Md.

MOTHER — 14. Maiden Name –
15. Birthplace

16 (a) Informant Jessie A. Henry, Undertaker.
(b) Address Cambridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30-44 (month) (day) (year)
(c) Cemetery or Crematory Cemetery
Location Smithville Md.

18 (a) Funeral director Jessie A. Henry
(b) Address Camb. Md.

19 (a) (Date received by registrar) Registrar

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27- 1944, at 6.40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd. & 3rd. degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-26-44 at 6.30 P.M.
(b) Where did injury occur? Schroeder Garage, 14 N. Schroeder St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Clothes caught fire - gasoline vapors.

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 5-28-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17613 / 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 Lamont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 Lamont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Annapolis Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER
12. Name John Thomas
13. Birthplace Md
14. Maiden Name Mary White
15. Birthplace Md

16 (a) Informant Margozie Howard
(b) Address Severn Park P.O. Box 257

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-42 (month) (day) (year)
(c) Cemetery or crematory Wayman
Location A.A. Co. Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) MAY 28 1942 (Date rec'd by Registrar) (b) Hamilton Baltimore Md

NB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25-42 1942, at 1:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1942, to May 25 1942, and that I last saw him alive on May 24, 1942.

Immediate cause of death: CARDIO RENAL DISEASE — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd St Date signed 5-27-42

M. D. R. 1288-2

G 17614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160c

G 17614

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Allendale Rd St., 18 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Carlanna Hines

(a) Residence: No. 2112 Allendale Rd St., 18 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fml	W.	Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day, year) May 27, 1944

7. AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.
	—	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Infant

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) 2112 Allendale Rd
(State or country)

FATHER

13. NAME Wm R Hines

14. BIRTHPLACE (city or town) Maryland
(State or country)

MOTHER

15. MAIDEN NAME Edith Haines

16. BIRTHPLACE (city or town) Harrisburg Pa.
(State or country)

17. INFORMANT Mrs Edith Wm Hines
(Address) 2112 Allendale Rd

18. BURIAL, CREMATION, OR REMOVAL
Place Loudon Park Date 5/29 1944

19. UNDERTAKER William J Zickmund Sons
(Address) North & Pt. Aves.

20. MAY 29 1944 for Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 5/28, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 27, 1944, to May 28, 1944.

I last saw her alive on May 27, 1944. Death is said to have occurred on the date stated above, at 6 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Aspiration & Pneumonia	
Cord winds was raped 2 times grand	
Infant trach	

Other contributory causes of importance:

Child was small & looked very bad at birth

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19—

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No If so, specify —

(Signed) Ed L Zimmerman M. D.

(Address) 1657 Hartford Rd

NO. 15 WHEN FILLED, WITH UNDERLINING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 17615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G 17615 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County [redacted]
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove Hosp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Waller Li. Brown

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Arline Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1883

8. AGE: Years 60 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Arthursville, S. C. (Town, county, and state)

10. Usual Occupation Clerk - retired

11. Industry or business

FATHER
12. Name Mercer Brown
13. Birthplace Mercersburg, Pa.

MOTHER
14. Maiden Name Mary Ann Arthur
15. Birthplace Arthursville, S. C.

16 (a) Informant Mr. F. B. Scott
(b) Address 4403 White Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 29 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1944, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 2nd 1944 2 P M.
(b) Where did injury occur? Spring Grove Hosp
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Clothes ignited by cigaret

23. Signature Robert C. Graham M.D. Medical Examiner.
Date signed May 31 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

17616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17616
Registered No.

CA-68021

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Belmont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Abbott (William M. Abbott)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1867

8. AGE: Years 77 | Months 3 | Days 9 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unemployed (retired Clark)

11. Industry or business

FATHER
12. Name John Abbott (deceased)
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 29 1944 (Date filed with Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1944, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944 to 5/26 1944 and that I last saw him alive on 5/26 1944.

Immediate cause of death: Cardiac failure

Due to: H C V D

Due to:

Other Conditions: Gen. arteriosclerosis; pul. emphysema
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: no post

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M.D.
Address BCH Date signed 5/26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G 17617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Howard Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Howard Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER W. DAVIS

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/1872

8. AGE: Years	Months	Days	If less than one day
72	2	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Supt.

11. Industry or business Electrical Contractor

FATHER
12. Name Lawrence Davis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Griffith
15. Birthplace Md.

16 (a) Informant Mrs. Grace Davis
(b) Address 3108 Howard Park Ave.

17 (a) Burial (b) Date thereof 5/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 29 1944 Hamilton Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 26, 1944 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26, 1943, to May 25, 1944, and that I last saw him alive on May 25, 1944.

Immediate cause of death	Duration
Cachexia and toxemia	
Due to carcinoma - probably bronchogenic - left lung.	
Due to	
Other Conditions Chronic urinary tract infection secondary to prostatic condition.	

(Including pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: None.

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Dan G. Baughman M. D.

Address 1014 St. Paul St. Date signed 5-27-1944

17618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17618

Registered No. 80B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Oakenshaw Place (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William A. Gisriel

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1937

8. AGE: Years 6 Months 8 Days 16 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER 12. Name Wm. A. Gisriel
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth Wilson
15. Birthplace Balto. Md.

16 (a) Informant Wm. A. Gisriel
(b) Address 3414 Oakenshaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Evergreen Oak Ave. Woodlawn

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Pallbearers, Md.

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944, to May 27 1944, and that I last saw him alive on May 27 1944

Immediate cause of death Encephalitis — Duration

Due to —

Due to —

Other Conditions Rabies Pouch Cyst

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. Arthur Rosberg

Address St. Agnes Hosp. Date signed 5/27/44

G 17619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17619 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E. Calvert St.
(c) Hospital or institution: Union Memil. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kentucky County
(c) City or town Louisville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Lexington Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lily T. Castleman

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Col. James P. Castleman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 NOV. 1882

8. AGE: Years	Months	Days	If less than one day
61	6	27	hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr. William P. Tinsley
13. Birthplace Kentucky

MOTHER
14. Maiden Name Alice Cooke
15. Birthplace Kentucky

16 (a) Informant Col. James P. Castleman
(b) Address (alone)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/44 (month) (day) (year)

(c) Cemetery or crematory Location New Castle, Ky.

18 (a) Funeral director John O. Metcalfe Sons
(b) Address 1900 Eutaw Place

19 (a) MAY 29 1944 (Registrar's record of death)

Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 May 1944, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 May 1944, to 29 May 1944, and that I last saw her alive on 29 May 1944.

Immediate cause of death	Duration
Cardiorespiratory Failure due to	
Due to Hypertensive Cardiovascular renal disease	Duration of symptoms
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Morris, M.D.
M. D.
Address U.M.H. Date signed 5-29-44

G 17620 MASTROCOLA. G 17620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Luzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas M. Mastrocola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1890

8. AGE: Years	Months	Days	If less than one day
54	3	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Metal Worker

11. Industry or business Brown Bak

FATHER
12. Name John Mastrocola
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Beale
15. Birthplace St. Catherine Ont.

16 (a) Informant Brother
(b) Address 200 N. Luzerne AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location

18 (a) Funeral director Frank V. Papitone
(b) Address 2518 E. Balto St

19 (a) (b)

MAY 29 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 9:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Strangulation due to Hanging

Due to

Other Conditions mental deficiency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 26 1944 M.
(b) Where did injury occur? 200 N. Luzerne St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? By Hanging himself by
(d) Means of injury sheet

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.

Date signed 5-27-44

17621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

G 17621

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2870 W.Mulberry St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2870 W.Mulberry St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Emily R.Kelly,

3 (b) If veteran, name war

3 (c) Social Security Account No: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph F.Kelly,

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 28.1887

8. AGE: Years	Months	Days	If less than one day
57	1	29	..... hr. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER

12. Name: Emanuel Witts,

13. Birthplace: Baltimore Md

MOTHER

14. Maiden Name: Annie Schmidt.

15. Birthplace: Baltimore

16 (a) Informant: Joseph F.Kelly,

(b) Address: 2870 W.Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31.1944 (month) (day) (year)

(c) Cemetery or crematory: Baltimore National

Location: Baltimore Md.

18 (a) Funeral director: Robert S,Little,

(b) Address: 2700 Edmondson Ave.

19 (a) MAY 29 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7-44 19.., to 5-27 1944, and that I last saw h2 alive on 5-25-44

Immediate cause of death: Myocardial failure — Duration:

Due to: malignancy & metastases — 2 yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury:

23. Signature: Harry S. Lentz

Address 2703 Edmondson Date signed 5-29-44

G 17622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G 17622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Acha M. Waller

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/1905

8. AGE: Years	Months	Days	If less than one day
39	2	4	hr. min.

9. Birthplace Swanton, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Swamp Shoe Co.

FATHER
12. Name John Bayes
13. Birthplace Ohio

MOTHER
14. Maiden Name Cora Lawrence
15. Birthplace Ohio

16 (a) Informant Clyde Waller
(b) Address Fort Belvoir

17 (a) Removal (b) Date thereof 5-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Lawn
Location Portsmouth, Ohio

18 (a) Funeral director Williams-Cook Inc.
(b) Address 1217 St. Paul St

19 (a) MAY 29 1944 (b) Thurlington Williams, Jr. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27-1944, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-27-44 at 6 P. M.
(b) Where did injury occur? 2123 Maryland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self-inflicted gun-shot wound

23. Signature Howard J. Weldeis M.D.
Medical Examiner.
Date signed 5-28-44

1

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 17623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

925

G 17623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3139 Elmora Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGO NYBORG

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-1559

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1877

8. AGE: Years 67 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Sweden
(Town, county, and state)

10. Usual Occupation Tailor and Fitter

11. Industry or business K. Katz and Son

FATHER
12. Name Old Nyborg
13. Birthplace Sweden

MOTHER
14. Maiden Name Cecilia (unknown)
15. Birthplace Sweden

16 (a) Informant Mrs. Louise Nyborg
(b) Address 3139 Elmora Avenue

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/30/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAY 29 1944
VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1944, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. J. Wallenmeyer M.D.
Medical Examiner.
Date signed

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 17624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 17624 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun + Fayette
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Riverside Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lloyd Moler

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7418

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 | 23 | 86

8. AGE: Years 57 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Watchmaker

11. Industry or business Montgomery-Ward Co.

FATHER 12. Name Robert Moler

13. Birthplace Martinsburg W. Va.

MOTHER 14. Maiden Name Elizabeth Smoot

15. Birthplace Balto. Md.

16 (a) Informant Maggie Moler

(b) Address 1039 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (Signature of registrar) (b) Registrar

MAY 31 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/1944, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27/1944, to 5/28/1944, and that I last saw h alive on 5/28/1944

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to	
Other Conditions Partial Intestinal Obstruction - Prostate	4 weeks

(Include pregnancy within three months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. J. Lusby M.D.

Address Fr. Sq. Hosp Date signed 5/28/44

Correct age in typewriting immediately. Physician: please write the causes of death clearly and legibly.

G 17625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 17625 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5422 Narcissus Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Italy

3 (a) FULL NAME Pietro Raymond (Raimondi)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Nicolina Raimondi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1878

8. AGE: Years	Months	Days	If less than one day
65	5	2	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Boiler Maker

FATHER
12. Name Salvatore Raymondi
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela Grispi
15. Birthplace Italy

16 (a) Informant Salvatore Raymond
(b) Address 5320 Cordelia Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAY 29 1944 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 1.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to May 27 1944, and that I last saw him alive on May 27 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Infarction	
Due to Thrombophlebitis, leg	?
Other Conditions Congestive Ht. failure Bronchopneumonia & B.P.H. (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Sinai Hosp. Date signed 5/17/44

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17626 454505

BALTIMORE CITY HEALTH DEPARTMENT V G 17626

CERTIFICATE OF DEATH 1318

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Park Lawn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Cicierski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-19

8. AGE: Years 24 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Pay Roll Clerk

11. Industry or business

FATHER
12. Name Louis Cicierski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Ruczynski
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

MAY 29 1944 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944, to May 26 1944 and that I last saw her alive on May 26 1944.

Immediate cause of death: Chronic nephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Date signed 5-25-44

17627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G 17627
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Mohawk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S Parkside
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R Snowden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katherine L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1875

8. AGE: Years 68 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Wilbur L. Snowden
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Raley
15. Birthplace Maryland

16 (a) Informant Mrs Katherine Snowden
(b) Address 3708 Mohawk Ave

17 (a) Burial (b) Date thereof 5-30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director George E Fayette
(b) Address Eastern Ave & Fayette

MAY 29 1944
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1943 to 5-27 1944
and that I last saw him alive on 5-26 1944

Immediate cause of death	Duration
Myocardial Failure.	days
Due to Arteriosclerosis & Chronic Interstitial Nephritis	?
Due to and Hypertension and Uremia.	12
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry E Bogrod M.D.
Address 905 N Baltimore St Date signed 5-29-44

VS 150

6 17628 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. 6 17628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 Somerset (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY Theresa Richardson (MATHEWS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1885

8. AGE: Years	Months	Days	If less than one day
59 54	0	25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John F. Silversack
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Tuescheck
15. Birthplace Germany

16 (a) Informant Mrs. John P. Ray
(b) Address 1712 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

MAY 29 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. L. Wallenmeier M.D. Medical Examiner.
Date signed 5-29-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17629 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G 17629 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Colombia (b) County.....
(c) City or town Cartagena
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Colombia, S. America

3 (a) FULL NAME Mr Antonio Pedro Jaspe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married) widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mrs Rose Jaspe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1870

8. AGE: Years	Months	Days	If less than one day
73 74	7	8	....hr. ....min.

9. Birthplace South America (Town, county, and state)
10. Usual Occupation Advisor
11. Industry or business

FATHER
12. Name Mr Jose Jaspe
13. Birthplace South America

MOTHER
14. Maiden Name Clara Diet Real
15. Birthplace South America.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

MAY 29 1944 (Date rec'd by Registrar) Hampton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944, to May 27 1944, and that I last saw h him alive on May 27 1944.

Immediate cause of death Bronchogenic Cancer with Metastases. — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. D. Morris, M.D.
Address ADMH. Date signed 5-27-44
M. D.

17630 — BALTIMORE CITY HEALTH DEPARTMENT — G 17630

CERTIFICATE OF DEATH

Registered No. 83a

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Richardson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 66yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Richardson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert H. Sommer

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 5, 1863

8. AGE: Years	Months	Days	If less than one day
81	-	21 24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Albert Sommer
13. Birthplace Germany

MOTHER
14. Maiden Name Wilamena Fabor
15. Birthplace Germany

16 (a) Informant Mrs. Marie Sommer
(b) Address 1422 Richardson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 44 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Violettville

18 (a) Funeral director L. Heemann and Son
(b) Address 32 S. Broadway

19 (a) Date received MAY 29 1944 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 11 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944 to May 26 1944 and that I last saw h. alive on May 25 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	?
Due to Cerebral sclerosis	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Lee Hitchens M.D.
Address 4116 Northern Pkwy Date signed 5/27/44

G 17631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 17631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 558 Baker St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Madison County N.Y.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Robinson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife Elizabeth Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-1912

8. AGE: Years 31 | Months 6 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Robinson
13. Birthplace md

MOTHER
14. Maiden Name Martha Valentine
15. Birthplace md

16 (a) Informant Charles Robinson
(b) Address 558 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Lloyd L. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) Huntington Williams Mgr. (Registrar)

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 2a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28 1944 to 5-26 1944, and that I last saw h alive on 5-26 1944

Immediate cause of death Pulmonary T.B.

Duration 6 Mos

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. N. Pratt M.D.

Address 1536 W. Lowndes St. Date signed 6-29-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17632 ✓ G 17632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Brune St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Brune St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elison Ward

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	married

6 (b) Name of husband or wife Martha Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1884

8. AGE: Years	Months	Days	If less than one day
60	4	9	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Martha Ward
(b) Address 716 Brune St

17 (a) Burial (b) Date thereof 5-31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Watson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Hillsdale, Md

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1943 to May 27 1944 and that I last saw h alive on May 27 1944

Immediate cause of death
Hypertension Cardiac - Renal - Vascular

Duration
4 Mo

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hafetz M. D.
Address 1 W 55 St Date signed 5/29/44

17633
AB-87987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G 17633

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Marey (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31-1898

8. AGE: Years 45 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Jones (D)
13. Birthplace S.C.

MOTHER
14. Maiden Name Maria Sommers (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location C. A. Co Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) MAY 29 1944 (Date received by registrar) Huntington Wilkinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1944 at 9.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1944, to 5-26 1944, and that I last saw her alive on 5-26 1944

Immediate cause of death — Duration

Uremia — 7

Due to Intestinal Obstruction

Due to Adhesions

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-22-44

Major findings of operation: Intestinal Obstruction

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald Bostock M. D.
Address Balto City Hosp Date signed 5-27-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17634
28-88234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 17634
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?-

8. AGE: Years	Months	Days	If less than one day
27 ?	?	?	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Nelson Johnson (D)
13. Birthplace S.C.

MOTHER
14. Maiden Name Hannah Clark
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Sumter
Location S.C.

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 16 E. W. Montgomery St

19 MAY 29 1944 Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 4.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1944, to 5-28 1944, and that I last saw him alive on 5-25 1944.

Immediate cause of death	Duration
Uremia	5 days
Due to Nephritis (?) tuberculosis kidney	years
Due to	years
Other Conditions Pneumonia	10 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathias M. D.
Address B. C. H. Date signed 5/28/44

17635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

G 17635
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 1618 Madison Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Provident Hospital
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Janit Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 21, 1944
8. AGE: Years | Months | Days 2 | If less than one day hr. min.
9. Birthplace Baltimore, Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Alfred Williams
13. Birthplace Florence, S. C.

MOTHER
14. Maiden Name Dorothy Waddell
15. Birthplace Danville, Virginia

16 (a) Informant Dorothy Williams
(b) Address 1618 Madison Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 5/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem Co
Location Mt. Wilson
18 (a) Funeral director Chas H. Aberdeen
(b) Address 1201 McCulloh St
19 (a) MAY 3 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23-1944, at 1:40 M
21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1944, to 5-23 1944, and that I last saw him alive on 5-26 1944.

Immediate cause of death	Duration
Hemorrhagic Disease of Newborn	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. A. Purnell M. D.
Address 1514 Division St. Balt. Md. Date signed 5-29-44

G 17636 BALTIMORE CITY HEALTH DEPARTMENT ✓ D 17636 Registered No.

CERTIFICATE OF DEATH 170C

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Keil

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 216-09-2008

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married ✓

6 (b) Name of husband or wife Ella Marie

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 25 1882

8. AGE: Years	Months	Days	If less than one day
62	1	2	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Amer'cn Brewery

11. Industry or business

FATHER
12. Name Henry Keil
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Kreb
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth DiNicci
(b) Address 1513 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-44 (month) (day) (year)
(c) Cemetery or crematory Maryland
Location

18 (a) Funeral director Leonard Krug
(b) Address 5305 Dunford Rd

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27- 1944 at 2 10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Multiple Comminuted Fractures.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/27/44 at 8/2 4.10 P. M.
(b) Where did injury occur? Bay, Chester Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 5/28/44

G 17639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 17637 Registered No. 13 1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4026 Echodale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4026 Echodale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry M. Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1867

8. AGE: Years 76 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Stewart
13. Birthplace Ireland

MOTHER
14. Maiden Name Rachel McAllister
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine K. Stewart
(b) Address 4026 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard Brusk
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 29 1944 [illegible] Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 11-20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to May 26 1944 and that I last saw h alive on 19

Immediate cause of death Uremic Coma

Due to Chr Nephritis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration 5/23/44
5/1/44
1936

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bauer
Address 801 41 Edmondson Ave Signed M. D. 5/28/44

G 17638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 17639 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Adele Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Matthew J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1902

8. AGE: Years 42 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Schwensen
13. Birthplace ?

MOTHER
14. Maiden Name Mary Dubbel
15. Birthplace Baltimore

16 (a) Informant M- Matthew J. Smith
(b) Address 3126 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 - 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard Hartge Ed
(b) Address 5-3 0 S Hilford Rd

19 (a) MAY 29 1944 (Date rec'd by registrar) Registrar

VS 150

Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 27 1944 at 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1944, to 5-27 1944, and that I last saw her alive on 5-27 1944.

Immediate cause of death Carcinomatosis — Duration 21da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-20-44 Ileostomy

Major findings of operation: Carcinomatosis of abdominal viscera

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stanley B. Klyanowicz M.D.
Address St Josephs Hosp Date signed 5/29/44

G 17639 — BALTIMORE CITY HEALTH DEPARTMENT — G 17639

CERTIFICATE OF DEATH

1312 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eleanor Watkins
3 (b) If veteran, name war —
3 (c) Social Security Account No. none
4. Sex 4
5. Color or race Col
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Gilbert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 17, 1903
8. AGE: Years 40 | Months 7 | Days 9 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Basil Lee
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Gilbert Watkins
(b) Address 2201 Druid Hill Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md
18 (a) Funeral director Wm. H. Gibson
(b) Address 303 Pressman St
19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1944, at 11:30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1944 to 5/26 1944, and that I last saw her alive on 5/26 1944

Immediate cause of death	Duration
Acute Dilatation	
Due to Chr. Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank Cutty M. D.
Address 2y Druid Hill Ave Date signed 5/26/44

VS 104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 17640
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Carroll St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Gibbons

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-4722

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Hartmann

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Jan 11 1888

8. AGE: Years 55 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Crisfield Md.
(Town, county, and state)

10. Usual Occupation auditor

11. Industry or business auto factory.

FATHER
12. Name Samuel Gibbons
13. Birthplace Pocomoke City Md

MOTHER
14. Maiden Name Ruth Ritze
15. Birthplace Crisfield Md

16 (a) Informant Mrs Lazzie Gibbons.
(b) Address 1112 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Md

18 (a) Funeral director Roy E. Emmert
(b) Address 1600 Hollins

19 (a) (Registrar) (b) (Date received by Registrar)

MAY 29 1944
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 8 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to May 26 1944, and that I last saw deceased alive on May 26 1944.

Immediate cause of death: Acute Heart Failure — Duration: 1 day
Due to: Myocarditis
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Glass M. D.
8 N. Eutaw Walworth 2211
Date signed 5/28/44

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

4540 G 17641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G 17641

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Caroline (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Cargill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-16-30

8. AGE: Years 13 | Months 10 | Days 19 12 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Dr. William Cargill
13. Birthplace Md

MOTHER
14. Maiden Name Bertha Harring
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 6-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Park
Location Baltimore Md

18 (a) Funeral director Thos. Thurston & H. Hemsley
(b) Address 578 W. Baltimore St

(a) (b)
(Signature of local registrar)

MAY 29 1944

Registrar

Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1944 at 10.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 11 1944 to MAY 28 1944 and that I last saw HIM alive on MAY 28 1944

Immediate cause of death Welch Bacillus infection - appendical & subphrenic Abcesses & Empyema — Duration 2 weeks

Due to Perforated Appendix — 2 weeks

Due to

Other Conditions

(Include pregnancy within 3 months)

Date of operation 5/11/44, 5/27/44

Major findings of operation: Appendicial Abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr.
Address Johns Hopkins Hospital Date signed 5/28

321897 G 17642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17642 Registered No. 1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St Mary's
(c) City or town Ridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Hopewell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female
5. Color or race black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-69

8. AGE: Years 75 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name Peter Jones
13. Birthplace ?

MOTHER 14. Maiden Name Mary Welder
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-44 (month) (day) (year)
(c) Cemetery or crematory St. Peter's Cem
Location St. Mary's Co. Md

18 (a) Funeral director Pius D. Robinson
(b) Address Barnesville, Md Huntingtown, Md

19 (a) (Date received) MAY 29 1944 (b) Registrar

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944 at 10 29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to May 27 1944 and that I last saw h[illegible] alive on May 27 1944

Immediate cause of death: Tuberculous pericarditis — Duration

Due to: Tuberculous

Due to: pleural effusion

Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not reported

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address JNN Date signed 5/28

G 17643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17643 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1073 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1073 W. Lexington St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1868

8. AGE: Years	Months	Days	If less than one day
75	11	6	hr. min.

9. Birthplace West River Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Hall
13. Birthplace West River Maryland

MOTHER
14. Maiden Name Smaje
15. Birthplace West River Maryland

16 (a) Informant James A. Hall
(b) Address 1073 West Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Pisky
(b) Address 469 N. Mount Street

19 [illegible] 29 1944 (b) [illegible] Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to May 26 44 and that I last saw h[illegible] alive on 5-26 44

Immediate cause of death	Duration
Hypostatic pneumonia Cardiac disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. N. Pisky M. D.
Address 1364 Lansdale Date signed 5-26-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a

G 12644 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roscoe F. CLARK.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1900

8. AGE: Years 44 | Months - | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Berkeley Springs W. Va. (Town, county, and state)

10. Usual Occupation Carpenter.

11. Industry or business

FATHER
12. Name James R. Clark
13. Birthplace W. Va.

MOTHER
14. Maiden Name Catherine McCusker
15. Birthplace Pa.

16 (a) Informant C. F. Hunter
(b) Address Burkley Springs W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cem
Location Burkley Springs W. Va.

18 (a) Funeral director Wm. J. Falkner & Son
(b) Address Balto., Md.

19 (a) 5/29/44 (Date rec'd by registrar) (b) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1944 to 5/29 1944, and that I last saw h[illegible] alive on May 28, 1944.

Immediate cause of death	Duration
Ur. empyema	
Fibrillation	
Due to Unknown cause.	1 year.
Due to	
Other Conditions Residual ad. Leuniparesis. (Include pregnancy, within 3 months of death)	1 year.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Thompson
Address So Balto Gen Hosp Date signed 5/29/44

G 17645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1937 G 17645

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH Jefferson Apartments

CITY OF BALTIMORE: (No. 4 East 32nd St., 7 Ward)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME William Bernard Mulhall

If U. S. Veteran specify WAR

(a) Residence: No. 4 East 32nd St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lelia Adelaide Mulhall

6. DATE OF BIRTH (month, day, year): August 20, 1878

7. AGE: Years 65; Months 9; Days 7; If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Investigator

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Internal Revenue

10. Date deceased last worked at this occupation (month and year): 11/43

11. Total time (years) spent in this occupation: 25yrs

12. BIRTHPLACE (city or town) (State or country): Washington D.C.

FATHER

13. NAME: James E. Mulhall

14. BIRTHPLACE (city or town) (State or country): Washington D.C.

MOTHER

15. MAIDEN NAME: Anna Burns

16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT: Mrs. Lelia Adelaide Mulhall (wife)
(Address) 4 East 32nd St

18. BURIAL, CREMATION, OR REMOVAL
Place: ~~Burial~~ London Pk Date: 5/30/ 44

19. UNDERTAKER: WM. J. TICKNER & SONS
(Address)

20. FILED: 5/29/44, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): May 27, 1944

22. I HEREBY CERTIFY, That I attended deceased from November 18, 1943, to May 27, 1944

I last saw him alive on May 25, 1944. Death is said to have occurred on the date stated above, at 7:30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerotic Heart Disease - Auricular Fibrillation	1936
Coronary Occlusion	5/27/44

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) W. Grafton Hersperger M. D.

(Address) 214 Medical Arts Bldg

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 8

G 17646

G 17646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

65B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 St. Johns Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

65B

3 (a) FULL NAME Margaret Patterson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 23, 1877

8. AGE: Years 66 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William F. Patterson

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Annie Lawson

15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Rose Patterson

(b) Address 631 St. Johns Road

17 (a) Burial (b) Date thereof 5/31/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 508 N. Calvert St.

MAY 29 1944 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 15 1944, to May 25 1944, and that I last saw h.. alive on May 25 1944

Immediate cause of death: Cardio - respiratory failure — Duration

Due to

Due to

Other Conditions: Adrenal insufficiency, Thrombophlebitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: Adrenal infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Azzuolo M. D.

Address Mercy Hosp. Date signed 5-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

6 17647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1952

6 17647

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Bridle Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1920

8. AGE: Years	Months	Days	If less than one day
24	2 3	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Merchant marine

FATHER
12. Name William Bridle Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Viola Mills
15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles P. Powell
(b) Address 2427 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 29 1944 Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to May 28 1944, and that I last saw him alive on May 28 1944.

Immediate cause of death	Duration
Rheumatic Heart Disease with congestive failure	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Calder M. D.

Address U. S. Marine Hospital Baltimore, Md. Date signed 5/28/44

17648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17648

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: St Joseph's Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. 21

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5601 Belair Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. James C Colvin

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-2327

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	divorced

6 (b) Name of husband or wife Margaret Beyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1879

8. AGE: Years	Months	Days	If less than one day
64	6	6	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Estimator

11. Industry or business Enterprise Roofing Co.

FATHER
12. Name John R. Colvin
13. Birthplace Va.

MOTHER
14. Maiden Name -- McCauley
15. Birthplace Va.

16 (a) Informant Mrs. Hammond Bradfield

(b) Address 5601 Belair Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof May 30, 1944 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto., Md.

18 (a) Funeral director Lowe & Son Funeral Home

(b) Address 7401 Belair Road

19 MAY 29 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 15

20. DATE OF DEATH 5-27 1944, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1944 to 5-27 1944 and that I last saw him alive on 5-26 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 5-27-44

VS 150

17649 BALTIMORE CITY HEALTH DEPARTMENT X G 17649
CERTIFICATE OF DEATH V 30E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town) Overlea
(d) Street No. 8 W. Overlea Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lydia Alice Froelich
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. widowed
6 (b) Name of husband or wife George Froelich
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 1st 1861
8. AGE: Years 83 Months 3 Days 26 If less than one day ..... hr. ..... min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Lancaster
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs. A. H. Porter
(b) Address 8 W. Overlea Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 30 44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.
18 (a) Funeral director Carlson Funeral Home
(b) Address 7401 Belair Rd
MAY 29 1944 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 7:15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944, to May 27 1944, and that I last saw h.e. alive on May 27 1944.

Immediate cause of death: Hypertension, syphilitic heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed May 29 1944

VS 150

17650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 467

G 17650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or Institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 98 Dundalk Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME: CHARLES T. HARLEY
3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Ida L. Harley
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17, 1858

8. AGE: Years	Months	Days	If less than one day
85	11	10	..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Retired

FATHER
12. Name Joseph L. Harley
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Eliz. Annie Boone
15. Birthplace Anne Arundel Co., Md.

16 (a) Informant Mrs. Chas. T. Harley
(b) Address 98 Dundalk Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof May 31, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Road

19 (a) MAY 29 1944 (Date rec'd by Reg.) (b) [illegible] for [illegible], Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27th 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1943, to May 26 1944 and that I last saw him alive on May 26th 44

Immediate cause of death	Duration
Carcinoma of Rectum	18 mths
Due to	
Due to	
Other Conditions Contributing Pernicious Anemia (Include pregnancy within 3 months of death)	yrs

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter M. Hammett M. D.
Address Baldwin Date signed 5/28/44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59B

Registered No. 17651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Use figures for dates. Be sure to correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4412 Parkmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Parkmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY STROBEL

3 (b) If veteran, name war: *
3 (c) Social Security Account No. **

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1860

8. AGE: Years	Months	Days	If less than one day
83	11	23	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Geo. Strobel
13. Birthplace Germany

MOTHER
14. Maiden Name Annie E. Simon
15. Birthplace Germany

16 (a) Informant Mrs. Lena Schiller
(b) Address 4412 Parkmont Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof May 31, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Balto., Md.

18 (a) Funeral director Rosehill Funeral Home
(b) Address 7401 Belair Road Huntington Williams, Mgr.

19 (a) MAY 29 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th, 1944, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to May 28 1944, and that I last saw h[illegible] alive on May 27 1944.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 wks
Due to: Arteriosclerosis — 9 yrs
Due to: High Blood Pressure — "
Due to: Arthritis — "
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. L. Finnyfrock M.D.
Address 2858 Hartford Rd. Date signed 5/29/44

VS 150

17652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G 17652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Walther Blvd.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clara A. List

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife J. Henry List

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1881

8. AGE: Years 63 | Months 10 | Days 29 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Grundisa
13. Birthplace Balto, Maryland

MOTHER
14. Maiden Name Josephine O'Dell
15. Birthplace Va.

16 (a) Informant Mr. J. Henry List.
(b) Address 4303 Walther Blvd.

17 (a) Burial (b) Date thereof 6/1/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore, Md

18 (a) Funeral director Langley Funeral Home
(b) Address 7401 Belair Rd

MAY 29 1944 (b) [illegible]
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 12:05 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed May 29, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17c

G 17653

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Found Phelps Rd at Essex Md
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 S Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 29 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

0977

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1944, at 10:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of back fracture of pelvis and numerous ribs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur? Route #40
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by auto

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed May 8 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 17654 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henriette M. Donovan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francis X. Donovan

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 23, 1884

8. AGE: Years 59 | Months II | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John McGronan
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Rose O'Hanlon
15. Birthplace Philadelphia, Pa.

16 (a) Informant Francis X. Donovan
(b) Address 1512 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/ 31/ 44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) ..... (b) .....
(Date received by registrar) Registrar

MAY 29 1944 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1942, to May 27 1944, and that I last saw her alive on May 26 1944

Immediate cause of death, Duration
(a) Uremia 2 Days
Due to (b) Chr. Cardio Vascular Renal disease 5 yrs
Due to
Other Conditions Hemiplegia 7 Days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 190 Eutaw Date signed 5/30/44

C-12655 — C-12655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

Registered No. 12655

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 N. Bentalow 11
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N. Bentalow 11 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John. Scott. Hand.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 17 1872

8. AGE: Years 72 | Months 2 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name John H. Hand
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Scott
15. Birthplace Balto. Md.

16 (a) Informant Mrs. John H. Hand
(b) Address 915 N. Bentalow 11

17 (a) Burial (b) Date thereof (burial, cremation, or removal) May 30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road.

18 (a) Funeral director John A. McGan
(b) Address 3000 E. Balto. St.

19 (a) [illegible] (b) Registrar
NOV 29 1944
VS 150
Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944, to May 27 1944, and that I last saw h[illegible] alive on May 27 1944.

	Duration
Immediate cause of death Cardiac Fibrillation	
Due to Carcinoma of	6 m
Due to mesentery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. K. Lynch M.D.
Address 237 Arnold Date signed 5/31/44
(OCEN)

G 17656
B-17656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

58a

G 17656
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 144 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Peddicord

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26-1924

8. AGE: Years 9 | Months 10 | Days 2 | If less than one day: hr. 1934 min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name George E. Peddicord
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eva Souders
15. Birthplace Balto. Md.

16 (a) Informant Geo. E. Peddicord
(b) Address 144 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Taylor Ave

18 (a) Funeral director John E. McGann
(b) Address 3000 E. Balto. St.

19 MAY 29 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 45

20. DATE OF DEATH May 28 1944 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1944 to 5-28 1944, and that I last saw him alive on 5-27 1944

Immediate cause of death: Cardiac failure — Duration

Due to: Pericardial effusion — Duration

Due to: Rheumatic pericarditis — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Vegetations on mitral valve, cardiac dilatation, pericardial effusion

of autopsy: positive involves

22. If death was due to external causes, fill in (a), (b), (c), (d), and (e):
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature T. Brennan M. D.
Address St Joseph Hospital Date signed 5-28-44

G 17657 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

G 17657 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Wyesche (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene S Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Alfred Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19 1896

8. AGE: Years	Months	Days	If less than one day
47	5	11	hr. min.

9. Birthplace Green Co. N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Shuggs
13. Birthplace Green Co. N.C

MOTHER
14. Maiden Name Dora Jackson
15. Birthplace La Grange N.C.

16 (a) Informant Alfred Brown
(b) Address 760 Wyesche

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Rocky Mount
Location North Carolina

18 (a) Funeral director Mr Katie R Williams
(b) Address 322 N Schroeder St

MAY 30 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1944 at 10.30 PM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B McNally M.D. Medical Examiner.
Date signed 5/26/44

Be sure the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 17658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 871

G 17658 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 455 Gale av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 455 Gale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecilia E. Keyes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3 - 1895

8. AGE: Years 49 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md. (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business Retired

MOTHER / FATHER

12. Name Hugh Keyes

13. Birthplace Scotland

14. Maiden Name Cath. A. Hill

15. Birthplace Scotland

16 (a) Informant Rose & Cath. Keyes

(b) Address 455 Gale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-44 (month) (day) (year)

(c) Cemetery or crematory Mass. Cath. Pt.

Location Old Frederick Rd.

18 (a) Funeral director John A. Moran

(b) Address 3002 E. Balto. St.

19 (a) (Date received by registrar) MAY 29 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29. 1944. at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to May 29 1944 and that I last saw her alive on May 29 1944

Immediate cause of death Acute Insufficiency — Duration 15 hrs

Due to Multiple Sclerosis — Duration over 10 yrs

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. I. C. Pelletier M. D.

Address 817 Hamilton Ter. Date signed

315105

G 17659

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

G 17659 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 John St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Stuart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-02

8. AGE: Years 41 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Maximillian Bouvia
13. Birthplace Md

MOTHER 14. Maiden Name Maggie Bouvia
15. Birthplace Md

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof May 30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pisgah Cem
Location Pisgah Md

18 (a) Funeral director Hendt & Ryan
(b) Address Waldorf Md

19 (a) (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MAY 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 May 27 1944 and that I last saw her alive on May 27 1944.

Immediate cause of death: Carcinoma, site ? Duration

Due to: origin undetermined,

Due to: ? pelvic mass,

Other Conditions: bony erosion ? ileum and lung metastases

(Include pregnancy within 3 months of death)

Date of operation: Anemia

Major findings of operation: node showed carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Bunningham M. D.

Address JHH Date signed 5/29/44

G 17660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5/31a

G 17660 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528-E-20-St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528-E-20-St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Goodwin Lindsay

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Walter R. Lindsay
6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.) Apr-5-1869

8. AGE: Years 75 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

MOTHER / FATHER
12. Name: Stephan R. Goodwin
13. Birthplace: Annapolis Md
14. Maiden Name: Mary J. Hopkins
15. Birthplace: Annapolis Md.

16 (a) Informant: Mrs May L. Fairbank (daughter)
(b) Address: 528-E-20-St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (To be signed by registrar) (b) Huntington Williams, M.D.

MAY 29 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27/44, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 19 44 to 5/27 19 44 and that I last saw h[illegible] alive on 5/27 19 44.

Immediate cause of death: Cardio vascular renal — Duration: 1 week — 5/20/44
Due to: Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Georgia Bowden
Address 1517 E North Ave Date signed 5/29/44 M. D.

G 17661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. G 17661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 N. Pearl Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Sarah) Rosaria Battaglia
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) February 26-1886

8. AGE: Years	Months	Days	If less than one day
58	3	-	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Philip Cascio
13. Birthplace Italy

MOTHER
14. Maiden Name Louise Cammarata
15. Birthplace Italy

16 (a) Informant Louise Mascre
(b) Address 320 N. Pearl Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Greenmount Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1944 to 5-25 1944 and that I last saw h[illegible] alive on 5-25- 1944.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Hypertension	yrs?
Due to Chronic Nephritis	yrs?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. D'Emanuele M. D.
Address Medical Arts Bldg. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHHELD FOR BINDING

W/B 1256pm

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

G 17662
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N Beechwood ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Edward Mc Colgan

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Helen Vaughan
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 7-23-81

8. AGE: Years	Months	Days	If less than one day
62	10	6 5	..... hr. ..... min.

9. Birthplace Balto. Md (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Mc Colgan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Tereda Reeder
15. Birthplace Md

16 (a) Informant Mrs. Helen V Mc Colgan
(b) Address Catonsville Md.

17 (a) Burial (b) Date thereof May 31 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address 1111 Harlem Ave Baltimore, Md

19 (a) 5/30/44 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1944 at 4.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1943 to 5/28 1944 and that I last saw him alive on 5/28 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	2 days
Due to Amyotraphic Lateral Sclerosis	?
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward Lange M.D.
Address Bon Secours Hosp Date signed 5/30/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

G 17663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

G 17663 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2046 Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Feinstein

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-09-3347

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace

16 (a) Informant Wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Joseph Louis Sue

(b) Address 1439 E. Baltimore St. Baltimore, Md.

19 (a) MAY 30 1944 (b)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 7.45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/26/44 at A. M.
(b) Where did injury occur? Sinai Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? no
(d) Means of injury Hanged self

23. Signature Reuben Feldman M.D.
Medical Examiner.
Date signed May 26 1944

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 17664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17664 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Seidman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Matilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Market Owner

11. Industry or business

FATHER 12. Name Soloman

13. Birthplace Russia

MOTHER 14. Maiden Name Fruma

15. Birthplace

16 (a) Informant Wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)

(c) Cemetery or crematory Beth Hebob

Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Chev

(b) Address 1429 E. Baltimore St

MAY 30 1944 (Date rec'd by registrar)

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 10 15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 15 5 55

(a) Date of injury May 28 1944 8 P M.

(b) Where did injury occur? Liberty Hgts & Tioga Pkwy

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Collision 2 autos

23. Signature Robert H. Pantzer M.D. Medical Examiner.

Date signed May 29 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G 17665 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Melmar Apts. C3
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Estelle Honigman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1910

8. AGE: Years	Months	Days	If less than one day
33	8	12	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER
12. Name Harry Honigman
13. Birthplace

MOTHER
14. Maiden Name Miss Ray Sachs
15. Birthplace

16 (a) Informant Ray Honigman
(b) Address Melmar Apts.

17 (a) Burial (b) Date thereof V-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Edmondson Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2439 E. Baltimore St

19 (a) MAY 30 1944 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944 at 11:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1944 to 5-28 1944, and that I last saw h[illegible] alive on 5-28 1944.

Immediate cause of death	Duration
Pneumothorax Cancer	
Due to Malignant Melanoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Rinehart M. D.
Address University Hosp. Date signed 5-29-44

G 17666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 17666 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Lipman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Wh
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Rena Lipman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1874
8. AGE: Years 70 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret
11. Industry or business

MOTHER / FATHER
12. Name Ennig —
13. Birthplace Russia
14. Maiden Name Fannie —
15. Birthplace Russia

16 (a) Informant Morris Lipman
(b) Address Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Washington Blvd.

18 (a) Funeral director Jos. Levine & Bro
(b) Address 1439 [illegible]

(b) (Date received by registrar) Registrar

MAY 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1944, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to May 25, 1944, and that I last saw him alive on May 25, 1944.

Immediate cause of death Pulmonary edema — Duration

Due to Lymphoblastoma ?

Due to myeloid purpides ?

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Meisels
Address Sinai Hosp Date signed 5/31

G 17667 BALTIMORE CITY HEALTH DEPARTMENT G 17667

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 N. FRONT ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. FRONT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL BERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife IDA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation MERCHANT

11. Industry or business

MOTHER / FATHER

12. Name LAIB BERMAN

13. Birthplace RUSSIA

14. Maiden Name FAGA

15. Birthplace RUSSIA

16 (a) Informant WIFE

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)

(c) Cemetery or crematory ROSEDALE

Location PHIL RD. & HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC.

(b) Address 1439 E. BALTO. ST.

19 (a) MAY 30 1944 (Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28- 1944 at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to May 28 1944, and that I last saw h[illegible] alive on May 27 1944.

Immediate cause of death: Acute Cardiac dilatation — Duration

Due to: Chronic myocarditis arterio. sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S C Feldman

Address 1440 E Balto Date signed 5-[illegible]-44

G 17668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 17668 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Aves.
(c) Hospital or institution:
Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 E. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris I. Leavey

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chaim
13. Birthplace Russia

MOTHER
14. Maiden Name Annie
15. Birthplace Russia

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Belair Rd & Bowleys Lane

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

MAY 30 1944 (Date received by registrar) (b) Thurston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1944 to 5-27 1944, and that I last saw him alive on 5-27 1944.

Immediate cause of death	Duration
Cerebral Haemorrhage	2 days
Arteriosclerosis, Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Leibman M. D.
Address Levindale Date signed

G 17669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17669 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Lightstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Pimlico Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

MAY 30 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/1944, at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24/1944 to 5/28/1944, and that I last saw her alive on 5/27/1944.

Immediate cause of death Cerebral accident. — Duration

Due to Embolism of cardiac origin? —

Due to Auric. Fibrillation - Thyroidism Hyt. disease —

Other Conditions Diabetes mell. —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald E Feselbaum

Address Sinai Date signed 5/30

G 17670 ✓ G 17670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Payton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/29/44

8. AGE: Years | Months | Days | If less than one day 9 hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bernard Payton ?
13. Birthplace

MOTHER 14. Maiden Name Alethia Payton
15. Birthplace Orangeburg S. C.

16 (a) Informant Flora Myers
(b) Address 1112 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1304 N. Central Ave

19 (a) (Date rec'd by reg'r) (year) (b) Registrar, M.D.

MAY 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 1944, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1944 to 5/29 1944 and that I last saw him alive on 5/28 1944.

Immediate cause of death	Duration
Asphyxia	
Due to Prolonged labor	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. R. Blake M. D.
Address 1327 N. Eastern (Date signed) 5/29/44

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G 17671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 17671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3513 Old York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. Wilkinson

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Elizabeth Wilkinson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 5. 1880
8. AGE: Years 63 | Months 11 | Days 23 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired Electrician
11. Industry or business Balto Police Dept
FATHER 12. Name James K. P. Wilkinson
FATHER 13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Martha Cummings
MOTHER 15. Birthplace Va
16 (a) Informant Martha J. Wilkinson
(b) Address 3513 Old York Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31. 1944 (month) (day) (year)
(c) Cemetery or crematory New Market
Location Maryland Line
18 (a) Funeral director Mr. & Mrs. John W. Geisel & Son
(b) Address 901 W. Fayette St.
19 (a) MAY 30 1944 (Date received by registrar) (b) Washington Mikawer

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 2.30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Late death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratcher M.D. Medical Examiner.
Date signed May 29, 1944

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

G 17672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 1/2 a Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Baltimore - 10. (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Hawthorne Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3. (a) FULL NAME Mrs. Marguerite Faile. (Henckel).

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Malcolm Faile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1881

8. AGE: Years	Months	Days	If less than one day
62	7	13	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business 0

FATHER
12. Name Francis Henckel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Reynolds
15. Birthplace New Jersey.

16 (a) Informant self.
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 30/44 (month) (day) (year)
(c) Cemetery or crematory H. Mary's
Location Burlington N.J.

18 (a) Funeral director Sidney H. Webster
(b) Address 4101 Edmondson Ave.

19 (a) [illegible] by registrar Hamilton Williams, M.D. [illegible] year

MAY 30 1944
VS 186 Fr. P.C. Gubernski, by Howard J. Anderson, M.D. 5/27/44

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1944 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944 to May 26 1944. and that I last saw h[illegible] alive on May 26 1944

Immediate cause of death	Duration
cardio-respiratory failure -	
Due to pulmonary emboli.	4½ min.
Due to	
Other Conditions intertrochanteric fracture of left hip. (Include pregnancy within 3 months of death)	

Date of operation 0
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence May 10th at 7 P.M.
(c) Where did injury occur? 405 Hawthorne Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell from chair

23. Signature Thomas P. Pfeffer M. D.
Address Union Memorial Hospital Date signed

Trans G 17673 RAY STEFFY G 17673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ray Steffy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased* (mo., day, yr.) April 11, 1901

8. AGE: Years	Months	Days	If less than one day
42	1	17	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business B & O

FATHER
12. Name John M Steffy
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Schenrode
15. Birthplace Maryland

16 (a) Informant Edwin T. Steffy
(b) Address 417 West Gate Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4101 Old Frederick Rd

18 (a) Funeral director Harry E Witte
(b) Address 4101 Edmondson Ave.

MAY 30 1944 Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 19 44 to 5/27 19 44 and that I last saw h[illegible] alive on 5/28 19 44

Immediate cause of death	Duration
Uremia	2 days
Due to Intestinal Obstruction	7 days
Due to Adhesions	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/27
Major findings of operation: Intestinal Obstruction, Adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Kemper M. D.
Address University Hospital Date signed 5/29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Street age is especially important.

File # 17674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17674 / 46a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Clearwater Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Mrs. Elsey Lee Sauk (Margaret M Sauk)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, (Married) widowed, or divorced.
6 (b) Name of husband or wife Mr. Elsey L. Sauk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1887

8. AGE: Years 56 | Months 7 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Sommers (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary (D)
15. Birthplace Ireland.

16 (a) Informant Husband
(b) Address Same June 1/44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Harry H. Wetzler
(b) Address 4101 E Baltimore St

19 (a) Filed by Clayton Williams, M.D. Registrar
(Date received by registrar) MAY 30 1944
VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29-44 19..., at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15- 1944 to 5-29 1944
and that I last saw he alive on 5-29 1944

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Ca. of Oesophagus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address U.M.H. Date signed 5-29-44

2 T 17675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 17675 Registered No. 940

Type, plan or information should be carefully supplied. Use write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Remington Ave & Wyman Park
(c) Hospital or institution: Marion Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2577 Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert A. Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-2840

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah M. nee Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1888

8. AGE: Years	Months	Days	If less than one day
56 36	3	6	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O. R.R.

FATHER
12. Name Joseph S. Fleming
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Ellwood
15. Birthplace England

16 (a) Informant Mrs. Sarah M. Fleming
(b) Address 2577 Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat.
Location 5500 Frederick Rd

18 (a) Funeral director Harry E. Wilkes
(b) Address 4101 Edmondson Ave

MAY 30 1944 (Date received by registrar) (b) Thurlow Nicholas, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenweber M.D. Medical Examiner.
Date signed May 27, 1944

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G 17676 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mag. A. Charnetz (Blan)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER — 12. Name ? Blumkis
13. Birthplace Lithuania ?

MOTHER — 14. Maiden Name Unknown
15. Birthplace Lithuania ?

16 (a) Informant Eugene Charnetz
(b) Address 731 West Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Joseph Kasinskas, Inc
(b) Address 602 Washington Blvd.

MAY 30 1944 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944, at 1015 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to May 27 1944 and that I last saw h-er alive on May 27 1944.

Immediate cause of death	Duration
Cerebral Embolism	6 hrs.
Due to Hypertensive Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Harry Lustman M. D.
Address 2617 Madison Ave Date signed 5-27-44

G 17677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

G 17677 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 Royston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Royston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles O. Meeks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Isabel V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/1868

8. AGE: Years	Months	Days	If less than one day
76 75	-	5	hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name
13. Birthplace Unknown

MOTHER 14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mrs M. Hammond.
(b) Address 3107 Royston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard Buck
(b) Address 5305 Harford Rd Baltimore, Md.

19 (a) (Date rec'd by registrar) Registrar

MAY 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1943 to 5-28 1944 and that I last saw h[illegible] alive on May 28 1944

Immediate cause of death	Duration
Arteriosclerotic cardio vascular-renal disease.	5 yrs.
Due to	
Due to	
Other Conditions Hypertrophy prostate	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Alessi M. D.
Address 6217 Harford Rd Date signed 5/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17678 — 322474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17678 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Clio (If outside city or town limits, write RURAL and give town)
(d) Street No. ✓ (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Teal
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-1905

8. AGE: Years	Months	Days	If less than one day
39	4	28	hr. min.

9. Birthplace Ala. (Town, county, and state)
10. Usual Occupation farmer
11. Industry or business

FATHER — 12. Name	James B. Teal
FATHER — 13. Birthplace	Ala.
MOTHER — 14. Maiden Name	Mary A. Dykes
MOTHER — 15. Birthplace	Ala.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/44 (month) (day) (year)
(c) Cemetery or crematory Dykes Cemetery
Location Clio Ala.

18 (a) Funeral director John Comstock Home
(b) Address 1960 Eutaw Place

MAY 30 1944 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944 at 705 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to May 29 1944, and that I last saw him alive on May 29 1944.

Immediate cause of death Recurrent cerebellar tumor — post operative. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/29/44

Major findings of operation: Cerebellar Tumor

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Crowders, M.D.
Address Johns Hopkins Hospital Balto. Md. Date signed 5/29/44

G 17679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

70c

G 17679

Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emer. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Robinson st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Geraldine Kirmse

3 (b) If veteran, name war: NO —
3 (c) Social Security Account No.: NONE —
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: SINGLE —
6 (b) Name of husband or wife:
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) JUNE 8 1941
8. AGE: Years 2 | Months 11 | Days 19 | If less than one day ____hr. ____min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name CASIMIR KIRMSE
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARGARET MITKA
15. Birthplace A.A.CO.

16 (a) Informant CASIMIR KIRMSE
(b) Address 507 S. ROBINSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 31/44 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

(a) MAY 30 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27- 1944, at 6 45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock

Due to Internal Hemorrhage

Other Conditions Numerous bruises on head, face, body - ex traumatic
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/27/44 at 6.30 P. M.
(b) Where did injury occur? Ford Motor Co. Eastern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Sweeney M.D.
Medical Examiner.
Date signed 5/28/44

G 17680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 17680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 day & 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 N. Janney Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EARLE STEWART

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of husband or wife Mabel Pyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/1895

8. AGE: Years 48 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation AB Seaman

11. Industry or business Merchant Marine

FATHER
12. Name Joseph E. Stewart
13. Birthplace N. J.

MOTHER
14. Maiden Name Lottie Wyable
15. Birthplace Philadelphia, Pa.

16 (a) Informant Records, U. S. Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeibe Sons.
(b) Address 403 South Wolfe Street

19 (a) Date received by registrar MAY 30 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1944, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12, 1944, to May 29, 1944, and that I last saw him alive on May 29, 1944

	Duration
Immediate cause of death: Emboli to brain and iliac arteries, acute	Unk.
Due to: Infarction of myocardium (acute)	Unk.
Due to: Arteriosclerotic coronary thrombosis	Unk.
Other Conditions: Arteriosclerotic heart disease	Unk.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 5/29/44

MS-52963

G 17681

TH. 86955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17681 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-Mo. & 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1206 McCullum Ct. McCulloh (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lois Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4th, 1932

8. AGE: Years	Months	Days	If less than one day
11	5	23	hr. min.

9. Birthplace N. C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William Smith

FATHER — 13. Birthplace N. C

MOTHER — 14. Maiden Name Hattie Shelton

MOTHER — 15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 30/44 (month) (day) (year)

(c) Cemetery or crematory

Location Raleigh N. Carolina

18 (a) Funeral director Mrs. Robert G. Elliott Dyt

(b) Address 1129 N. Carolina St.

MAY 30 1944 (Date rec'd by registrar) (b) Registrar

MAY 31 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27 1944, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1944 to 5-27 1944, and that I last saw h-r alive on 5-27 1944.

Immediate cause of death	Duration
Miliary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mathue M. D.

Address B.P.H. Date signed 5/28/44

G 17682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17682 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Fulton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Voigt

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 24, 1859

8. AGE: Years 85 | Months 2 | Days 4 | If less than one day ########## min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Louis Voigt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kirchgessner
15. Birthplace Germany

16 (a) Informant Miss. Bertha Keyser
(b) Address 15 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b) Date received MAY 30 1944 Registrar Huntington Williams, M.D.
VS 15c

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 1944 at 2:45 a M.

21. I certify that death occurred on the date above stated; that I attended deceased from OCTOBER 1943, to May 28 1944, and that I last saw h.e.s. alive on May 28 1944.

	Duration
Immediate cause of death: Myocardial failure	
Due to: Cerebral thrombosis	4 days
Due to: Generalized arteriosclerosis Hypertension C.V. disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Callahan M. D.
Address 24 W. Fulton Ave Date signed 5/29/44

G 17683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17683 Registered No. 1130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Cochranville (If outside city or town limits, write RURAL and give town)
(d) Street No. RFD 2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margie Bleuge Willis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Mr. Major Willis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1896

8. AGE: Years	Months	Days	If less than one day
48	2	19	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Peter Johnson
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Omie Bennett
15. Birthplace N. Carolina

16 (a) Informant Major Willis
(b) Address Oxford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-44 (month) (day) (year)
(c) Cemetery or crematory Mechanics Grove
Location Lancaster Pa.

18 (a) Funeral director J. E. Troeger
(b) Address Kirby, Penna

19 (a) MAY 30 1944 (Date rec'd by registrar) (b) Huntington Mills, Penna.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 4:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944 to May 30 1944 and that I last saw her alive on May 30 1944.

Immediate cause of death Uremia — Duration

Due to Glomerulo nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Lill III M. D.
Address Union Memorial Hosp Date signed 5-30-44

G 17684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92C

Registered No. G 17684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Since 5/18/44
(e) Length of stay in Baltimore (yrs., mos., or days): Just arrived

2. USUAL RESIDENCE OF DECEASED:
(a) State: Pa. (b) County:
(c) City or town: Warren
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 800 Conewingo Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: LEWIS ALEXANDER CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Marguerite Clancy
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-20-1894

8. AGE: Years	Months	Days	If less than one day
50	2	9	hr. min.

9. Birthplace: Warren, Pa. (Town, county, and state)
10. Usual Occupation: AB Seaman
11. Industry or business: Merchant Marine

FATHER
12. Name: Lewis M. Clark
13. Birthplace: Cincinnati, Ohio

MOTHER
14. Maiden Name: Mary E. Ryan
15. Birthplace: Pa.

16 (a) Informant: Records, U.S.Marine Hosp.
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-2-44 (month) (day) (year)
(c) Cemetery or crematory: St Josephs Cemetery
Location: Warren Pa.

18 (a) Funeral director: D Lee Odes
(b) Address: 644 York Rd.

19 MAY 31 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: May 29, 1944, at 6:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18, 1944 to May 29, 1944. and that I last saw h. im alive on May 29, 1944

Immediate cause of death: Acute perforation of the rectum at the rectal inguinoid junction with acute peritonitis — Duration: Several days

Due to:

Other Conditions: Rheumatic valvulitis, with deformity of valve, aortic sclerosis of aortic valve marked inactive, and

(Include pregnancy within 3 months of death)
Date of operation: 5/23/44-Hemorrhoidectomy
Major findings of operation: Hemorrhoids, internal and external
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: F K. Albrecht M. D.
Address: Baltimore, Md. Date signed: 5/30/44

MS-53048 ALBRECHT

17854 T77

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 57L Registered No. 17685

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 190 N.W. 100th Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jean Griffith
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-5-34
8. AGE: Years 9 Months 7 Days 24 If less than one day hr. min.
9. Birthplace VA (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eugene Griffith
13. Birthplace PA

MOTHER
14. Maiden Name May Elizabeth Coster
15. Birthplace Fla.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1/44 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat. Cem.
Location Arlington Va.

18 (a) Funeral director John C. Mitchell Sons
Address 1626 Eutaw Place

19 (a) MAY 31 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 1150 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to May 29 1944, and that I last saw her alive on May 29 1944.

Immediate cause of death Brain Tumor
as a result of Cerebellar Astrocytoma
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 5/27/44
Major findings of operation: Cerebellar Astrocytoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ian W. Chambers M.D.
Address Johns Hopkins Hospital Date signed 5/30/44

17686

JO #84785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. 17686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos. 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernie Chisholm

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1924

8. AGE: Years 19 | Months -6- | Days 15 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Floyd Chisholm
13. Birthplace South Carolina

MOTHER
14. Maiden Name Leasa Corwell
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/44 (month) (day) (year)
(c) Cemetery or crematory
Location Chester, S.C.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantley Ave
Norfolk Virginia

MAY 31 1944 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1944, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1943, to 11-16 1943, and that I last saw h[illegible] alive on 11-16 1943.

Immediate cause of death: Pulmonary tuberculosis — Duration: ?
Due to
Due to
Other Conditions: Tuberculous peritonitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Watson M.D.
Address 16 E 11 Date signed 5-31-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~17687~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

Registered No. G 17687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2836 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2836 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius Yagel (Yagella)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1st 1864

8. AGE: Years	Months	Days	If less than one day
80	3	27	hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Unemployed

FATHER
12. Name (Unknown) Yagella
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Russell S. Browning
(b) Address 2836 Harlem Ave

17 (a) Burial (b) Date thereof 5/31/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Stanislaus
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) MAY 31 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 1944, at 1.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to MAY 28 1944, and that I last saw h~~im~~er alive on May 25 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to arteriosclerotic type heart — Duration several years

Due to ~~Due to~~ —generalized arteriosclerosis

Other Conditions amputation of rt. forearm for bone malignancy

(Include pregnancy within 3 months of death)

Date of operation April 26-1944

Major findings of operation: Sarcoma of right ulna

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Date signed May 29 44

G 17688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

D 17688 17688

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Linden Ave.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA MONSERRAT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1850

8. AGE: Years	Months	Days	If less than one day
94			hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Oscar Monserrat
13. Birthplace -

MOTHER
14. Maiden Name Ellen Israel
15. Birthplace Mrs Edward J. Stegman

16 (a) Informant Mrs. ~~William~~ Stegman
(b) Address 303 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Clayton Williams, M.D. Registrar

VS MAY 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 4:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944, to May 29 1944, and that I last saw h[illegible] alive on May 28 1944

Immediate cause of death Myocarditis, Arteriosclerosis — Duration

Due to

Due to

Other Conditions Acut cardiac dialatation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. Kader M. D.
Address 2306 Eutaw Pl Date signed 5-30-44

G 17689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G 17689

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Mary Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Mary Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR J. CARTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna A. Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/1882

8. AGE: Years	Months	Days	If less than one day
61	5	18	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Penna. R. R.

FATHER
12. Name Richard Carter
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Bowen
15. Birthplace Md.

16 (a) Informant Mrs. Edna A. Carter
(b) Address 4100 Mary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hampden, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 31 1944 (b) Registered by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1944, at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 - 1943, to May 29 1944, and that I last saw h[illegible] alive on May 28 1944.

Immediate cause of death	Duration
Cancer of lung. - one month	
Diagnosis confirmed by X-Ray findings	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen C. Peetham
Address 3139 E. Baltimore St. Date signed 5-30-44 M. D.

PEETHAM

G 17690
309747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 17690
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 W. Lake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Col. Herman Doeleman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Natalie
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 8-25-74

8. AGE: Years	Months	Days	If less than one day
69	9	5	hr. min.

9. Birthplace Holland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Adrian Doeleman
13. Birthplace Holland

MOTHER
14. Maiden Name Wilhemina Woe
15. Birthplace Holland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Am.
Location Balto., Md.

18 (a) Funeral director Wm. J. Luckman Sons
(b) Address Balto., Md.

19 (a) Date received MAY 31 1944 (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May, 30 1944, at 3:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1944 to May 30 1944, and that I last saw him alive on May 30 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardiovascular disease	
Due to	
Other Conditions Arteriosclerosis, generalized (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Speed III M. D.
Address Johns Hopkins Hosp. Date signed 5-30-44

C 17691 ✓ C 17691

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 9th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Garrett Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** William Sparenberg (William Thomas Sparenberg)

3 (b) If veteran, name war: none none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Minnie Sparenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1881

8. AGE: Years	Months	Days	If less than one day
62	6	7	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Photographer
11. Industry or business Dept. Agriculture U. S.

FATHER
12. Name John Benard Sparenberg
13. Birthplace Balto.

MOTHER
14. Maiden Name Susan Freeburger
15. Birthplace Balto.

16 (a) Informant Mr. Benard Wm. Sparenberg
(b) Address 508 Stevenson Lane, Towson 4

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 31 1944 (Date rec'd by registrar) [signature] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29/44 19 , at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24/44 19 , to 5/29/44 19 , and that I last saw h m alive on 5/29/44 19 .

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Arteri-Sclerosis + Hypertension — [illegible]
Due to: C.V. Disease
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 5/29/44

C 17692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

C 17692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Pentridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Pentridge Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM L. GRIFFITHS

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-10-0812

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora Hopkins Griffiths
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/12/1879

8. AGE: Years	Months	Days	If less than one day
65	1	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business C. & P. Telephone Co.

FATHER
12. Name William Griffiths
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Garrett
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Cora H. Griffiths
(b) Address 1523 Pentridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 31 1944 (Date received by Registrar) for Milton Mus M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 29, 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944, to May 29 1944, and that I last saw h[illegible] alive on May 29 1944.

Immediate cause of death	Duration
Cardiac Asthma.	5 Yrs
Due to Arteriosclerosis Hypertension	5 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl Townsend M. D.
Address 806 N Fulton Ave Date signed 5/29/44

C 17693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

C 17693
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leila Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17. 1867

8. AGE: Years 76 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Richard T. Hunt

13. Birthplace Md.

MOTHER 14. Maiden Name Katherine Robins

15. Birthplace Va.

16 (a) Informant Richard T. Hunt

(b) Address 3410 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Md.

18 (a) Funeral director Charles E. Brazeck.

(b) Address 5701 Rock Spring Road

19. (a) Date received (month) (b) Registrar

MAY 31 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28. 1944 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19.. to 1944 19.., and that I last saw h.. alive on May 28 1944.

	Duration
Immediate cause of death: Cerebral Thrombosis	7 days
Due to arteriosclerosis	1 year
Due to Diabetes Mellitus.	1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Everett H. Mortensen Jr. M.D.

Address 2706 St Paul St Date signed 5/29/44

G 17694

G 17694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 Mosher Street
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 537 Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Meekins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Clarence Meekins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1897

8. AGE: Years	Months	Days	If less than one day
46 47	5	2	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Chandler
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Sharlter
15. Birthplace Va.

16 (a) Informant Clarence Meekins
(b) Address 537 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (Signature of registrar) MAY 31 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 5-28-44 19 , at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 43 to May 28 19 44 and that I last saw h alive on May 28 19 44

Immediate cause of death Coding - Nephritis and Uremia — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 5154 Arlington Date signed 5/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

MARGIN RESERVED FOR BINDING

G 17695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 17695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N. Patterson Park Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH WILHELMINA GLEICHMAN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Christian Gleichman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1865

8. AGE: Years 78 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: George A. Ott
13. Birthplace: Germany

MOTHER
14. Maiden Name: Don't know
15. Birthplace: Germany

16 (a) Informant: Mrs. Lillian Noland
(b) Address: 508 N. Patterson Park Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory: Trinity
Location: Baltimore, Md.

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans St.,

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 31 1944 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 years 19—, to May 28 1944, and that I last saw h— alive on May 27 1944.

Immediate cause of death Confinement of age + Carcinoma R Breast + Mitral Murmur — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature R. Perry Carman M.D. M. D.
Address 1201 N. Caroline St. Date signed May 28 44

17696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. C 17696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 120 A. St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie R. Gentry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Factory

11. Industry or business

FATHER 12. Name William Randolph

13. Birthplace Va.

MOTHER 14. Maiden Name Bettie Epps

15. Birthplace Va.

16 (a) Informant Ellen Smith

(b) Address W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

19 MAY 31 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21/1944, at 9.21 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 5/22/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 17697
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Block E. Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Albemarle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Lieberman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Lena Rachel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Shoe Maker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 (month) (day) 44 (yr.)
(c) Cemetery or crematory Hebrew Mt. Carmel Cemetery
Location Jerusalem Hall Road

18 (a) Funeral director Sol Levin & Bros.
(b) Address 1124-26 W. North ave.

MAY 31 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 186 For B. C. J. Lubinski by C. Thomas D. Medders, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to May 30 1944, and that I last saw h.. alive on May 29 44

Immediate cause of death Diabetic coma — Duration
Due to Diabetes mellitus
Due to
Other Conditions Fracture of left femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 5-26-44 at 8 A. M.
(c) Where did injury occur? 119 Albemarle St (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell downstairs.
23. Signature Harold Libow
Address Sinai Hosp. Date signed 5/29/44 M. D.

C 17698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

C 17698 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 171 W. Hamburg St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 171 W. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jasper William Long

3 (b) If veteran, name war	3 (c) Social Security Account No.
1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Pinkey Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1877

8. AGE: Years	Months	Days	If less than one day
46	7	8	hr. min.

9. Birthplace Warren County N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Long
13. Birthplace N. C.

MOTHER
14. Maiden Name Eliza Towns
15. Birthplace N. C.

16 (a) Informant Pinkey Long
(b) Address 171 Hamburg St

17 (a) Removal (b) Date thereof June 1, 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Norlina N. Carolina

18 (a) Funeral director Mrs. Otis G. Elliott & Son
(b) Address 1299 Carlisle St.

19 (a) MAY 31 1944 (Date received by Registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944 at 6.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1944 to May 29 1944 and that I last saw h. alive on May 29 1944

Immediate cause of death: Acute Lobar Pneumonia — Duration: 17 days

Due to: —

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Allen M. D.
Address 124 Augusta St. Date signed May 30

C 17699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No. C 17699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 School St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME GEORGE BENNETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife Susie Bennett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name George Bennett
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary
15. Birthplace S.C.

16 (a) Informant Susie Bennett
(b) Address 1412 School St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelly
(b) Address 1303 Pleasant

19 (a)..... (Date received by registrar) (b)..... Registrar

MAY 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-27-44 at 11 P. 15/1 M.
(b) Where did injury occur? Delaware & Lawrence
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
Means of injury Pedestrian struck by auto
Signature J. T. Wallenmeyer M.D. Asst Medical Examiner.
Date signed 5-30-44

correct age is especially important. Physicians: please write the

G 17700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 17700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 N. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John W. Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Widowed

6 (b) Name of husband or wife Nancy Harrison

6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Feb 29 1875

8. AGE: Years	Months	Days	If less than one day
69	3	-	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Josiah Harrison
(b) Address 108 N. Gilmore St

17 (a) Burial (b) Date thereof 6-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b)
(Signature and title) Registrar

MAY 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 1.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944, to May 23 1944, and that I last saw h[illegible] alive on May 23 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 weeks
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack T. Gorsen M. D.
Address 402 Edmondson Ave Date signed 5/30/44

C 17701 — BALTIMORE CITY HEALTH DEPARTMENT — C 17701

CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Jurak

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-2358

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine —

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June - 1887

8. AGE: Years	Months	Days	If less than one day
56	11	—	hr. min.

9. Birthplace Yugoslavia — (Town, county, and state)

10. Usual Occupation Crane Helper

11. Industry or business B & O. R.R.

FATHER — 12. Name Unknown

13. Birthplace

MOTHER — 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mary Jurak

(b) Address 403 S. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1-47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director Robt. C. & B.M. Walters

(b) Address 121 S. Strieker St.

19 (a) [redacted] (b) [redacted] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 9:22 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury May 29 1947 2:20 A.M.

(b) Where did injury occur? 403 S. Howard St

(c) Did injury occur at home, on farm, industrial place, in public place? at home - While at work? No

(d) Means of injury Fall down front steps

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed May 29 1947

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17702 Trans.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17702
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3325 Eaton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 Eaton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis H. Grese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Lott Emma J. nee Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1873

8. AGE: Years 70 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation Mail Carrier Retired

11. Industry or business U.S. Govt.

FATHER
12. Name Casper Grese
13. Birthplace Germany

MOTHER
14. Maiden Name Popp
15. Birthplace Germany

16 (a) Informant Harry B. Grese
(b) Address 5308 Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 E Lafayette Ave

19 (a) Filed by [illegible] (b) Registrar

MAY 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28/44, 1944, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to May 28 1944, and that I last saw h[illegible] alive on May 27 1944

Immediate cause of death Coronary Occlusion — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Frederick Rd. Date signed 5/30/44

17703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 17703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lemmons Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 645 N. Mulberry Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell James Clemons.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 24 Months Days If less than one day hr. min.

9. Birthplace SUFFOLK, Va. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name James CLemmons
13. Birthplace Marion S.C.

MOTHER
14. Maiden Name Louise Boynes
15. Birthplace Marion S.C.

16 (a) Informant James Clemmons
(b) Address 1039 Rice St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-1-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Anne Arundel Co Md

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 3-31-1944 Schroeder St

19 (a) MAY 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28-1944, at 2 20 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wound of chest involving aorta & lung.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-28-44 at 2 A M.
(b) Where did injury occur? 645 N. Mulberry St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gun shot

23. Signature Thomas J. Mendeis M.D.
Medical Examiner.
Date signed 5/28/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17704

File No. 68524 V132B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 George St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Warner Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1894

8. AGE: Years	Months	Days	If less than one day
49	5	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Reison (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem
Location Arbutus Md

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

MAY 31 1944 (b) [illegible] Huntingtown Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 7 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1944 to 5-28 1944, and that I last saw h[illegible] alive on 5-28 1944.

Immediate cause of death	Duration
Uremia	?
Due to Urinary Retention	?
Due to Pneumonia	?
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation 5-20-44

Major findings of operation: Urinary Retention

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Hebb

Address Balto City Hosp Date signed 5-26-44

(over)

G 17705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17705 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** ROSE M. JEFFERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late Wm W Jefferson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1872.

8. AGE: Years 71 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER
12. Name John M. Schwartz
13. Birthplace Germany

MOTHER
14. Maiden Name Oxenhorn
15. Birthplace Germany

16 (a) Informant Miss Schwartz
(b) Address #1006 Hollins Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location 5712 O'Donnell Street

18 (a) Funeral director John J Conway Son
(b) Address 900 03 W Hollins Street

19 (a) MAY 31 1944 (Date rec'd by registrar) (b) Huntington Withington M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944, at 2 30 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H 2 Wallenwiker M.D.
Medical Examiner.

Date signed 5-30-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

C 17706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 D

Registered No. C 17706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 E. 22nd st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 E. 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Thomas Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or wife~~: Verdie M. Brewer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23rd 1878

8. AGE: Years 65 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Printing & Publishing

11. Industry or business Own Business

FATHER
12. Name John W. C. Brewer
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Cumming
15. Birthplace "

16 (a) Informant Mrs Verdie Brewer
(b) Address 519 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
Address 1217 St. Paul St

19 (a) MAY 31 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 43 to May 30 1944, and that I last saw h[illegible] alive on May 29 1944

Immediate cause of death: Secondary Carcinoma Cachexia and Metastasis — Duration: 1 month

Due to: Carcinoma of Urinary Bladder, primary unknown — Duration: 1½ years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 2025 E Northern Date signed 6/30/44

G 17707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 17707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 N. Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM Arthur Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31, 1886

8. AGE: Years	Months	Days	If less than one day
57	4	2729	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Central Savings Bank

FATHER
12. Name Andrew Snyder
13. Birthplace Germany

MOTHER
14. Maiden Name Annie M. Hilman
15. Birthplace Balto., Md.

16 (a) Informant Alfred W. Snyder
(b) Address 2506 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St Paul St

19 (Date received) MAY 31 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 1944, at 8.15 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McNally, M.D. Medical Examiner.
Date signed 6/1/44

VS 161

correct age is especially important. Physicians: please write the

G 17708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 17708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Clifton Park Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Clifton Park Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR T. BLACK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Bertha Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1876

8. AGE: Years	Months	Days	If less than one day
68	2	18	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Continental Can Co.

FATHER
12. Name Levi Black
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Annie Robinson
15. Birthplace Carroll Co. Md

16 (a) Informant Mrs. Bertha Black
(b) Address 2816 Clifton Park Terrace

17 (a) Burial (b) Date thereof 6-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Md.
Location

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St Paul St

19 MAY 31 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944, at 8 50 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
for Medical Examiner.
Date signed 5-31-44

VS 151

Please write plainly, using pen and ink. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 1709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

G 1709 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Time correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Lenderdale Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4030 Falls Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Gertrude M. Ray

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William F. Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-1883

8. AGE: Years 60 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace East Berlin Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Daniel L. Baker
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Lydia Hollinger
15. Birthplace Pennsylvania

16 (a) Informant William F. Ray
(b) Address 4030 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 623 Falls Road

19 (a) JUN 31 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29 1944, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944 to 5-29 1944, and that I last saw her alive on 5-29 1944.

Immediate cause of death Carcinomatosis, Laparotomy, probably primary in stomach — Duration

Due to

Due to

Other Conditions Hypertension C.V. Disease

(Include pregnancy within 3 months of death)

Date of operation 5-22-44

Major findings of operation: above

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John DeYoung Jr. M. D.
Address Hosp. Gen. Hosp. Date signed 5-29-44

Huntington Williams, M.D.

G 17710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 17710

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3954 Pennhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Rothbard.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Oscar
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Hannah
15. Birthplace Austria

16 (a) Informant Sadie Rothbard
(b) Address 3954 Pennhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1-44 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) (Date rec'd by registrar) MAY 31 1944 (b) Huntington Pittsman, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944; at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to May 31 1944 and that I last saw him alive on May 31 1944

Immediate cause of death Cerebral Embolism
Duration

Due to Cerebral Embolism - Hypertension

Due to Asthma - ?? T.B.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dr Marks
Address Sinai Hosp Date signed 5/31

1771 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH √107 0 1771

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1647 Cuba St St., 24 Ward)

Length of residence in city or town where death occurred ..yrs. mos. 26 dys. How long in U. S. If of foreign birth? ..yrs. ..mos. ..dys.

2. FULL NAME Shirley M Duggan

If U. S. Veteran specify WAR.....

(a) Residence: No. 1647 Cuba St 30 St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 2-44

7. AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Thomas W Dugan.

14. BIRTHPLACE (city or town) (State or country) W Va.

MOTHER

15. MAIDEN NAME Mary M Hall

16. BIRTHPLACE (city or town) (State or country) W Va.

17. INFORMANT Mrs Mary M. Duggan.

(Address) 1647 Cuba St 30.

18. BURIAL, CREMATION, OR REMOVAL

Place Elkins W. Va. Date 5/31/44 19..

Mt Rose Baptist Cemetery

19. UNDERTAKER Geo M Mangelle

(Address) N Eutaw St

20. FILED MAY 31 1944 19.. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 30 1944

22. I HEREBY CERTIFY, That I attended deceased from May 28 1944 to May 30 1944

I last saw her alive on May 30 1944 Death is said to have occurred on the date stated above, at 7:45 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia	Day
Other contributory causes of importance: Broncho Pneumonia	3 Days

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation..... Date of.....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No. If so, how?

5/30/44 (Signed) T. R. Campbell M. D.

(Address) 1644 Hanover St.

vs. 3

information should be carefully supplied. Attempt should be made to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 17732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G 17732

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3310 Lawnview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Elsa Connelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Russell Connelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22. 1909

8. AGE: Years 34 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation house wife

11. Industry or business

FATHER
12. Name Carl Juptiz
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Wolf
15. Birthplace Germany

16 (a) Informant Russell F. Connelly
(b) Address 3310 Lawnview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) Date received MAY 31 1944 (b) Thurlington Williams, M.D. (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 19 44, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 19 44, to 5/30 19 44, and that I last saw her alive on 5/30 19 44.

	Duration
Immediate cause of death: Carcinoma of liver Metastatic.	1 yr.
Due to: Metastasis from Carcinoma of breast	Doubtful
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Kemper M. D.
Address Univ. Hospital Date signed 5/30

G 17713

JL - 87986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

Registered No. 17713

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Shaw

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1886

8. AGE: Years 57 | Months 9 | Days 4 3 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Cartwright
13. Birthplace England

MOTHER
14. Maiden Name Cynthia Wickwire
15. Birthplace N. Y.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) (Date received by registrar) (b) Registrar

MAY 31 1944

VS 100 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28-44, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13 1944, to 5-28 1944, and that I last saw h[er] alive on 5-28 1944.

Immediate cause of death: Coma — Duration: ?
Due to: Cirrhosis of Liver — Duration: ?
Due to: — Duration:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathue M.D.
Address B. C. H. Date signed 5/28/44

(OVER)

C 177.4 BALTIMORE CITY HEALTH DEPARTMENT C 177.4
CERTIFICATE OF DEATH 121 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brad[illegible] 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. Geraldine Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Austin Raspe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10-1903

8. AGE: Years	Months	Days	If less than one day
41	1	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Heat treater
11. Industry or business Defense Work

FATHER
12. Name William F. Raspe
13. Birthplace Md.

MOTHER
14. Maiden Name Rose McKenna
15. Birthplace Md.

16 (a) Informant Eleanor Raspe
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 1944 (month) (day) (year)
(c) Cemetery or crematory St. Stephens Cem.
Location Bradshaw, Balto. Co., Md.

18 (a) Funeral director John Burns Long
(b) Address Towson, Md.

19 (a) [illegible] (b) [illegible]
MAY 31 1944 [illegible] for Wilmer Krusen, M.D.
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 19 44 at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 19 44 to 5/29 19 44 and that I last saw h[illegible] alive on 5/29 19 44

Immediate cause of death Pulmonary Embolis — Duration
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations Chr. Appendicitis
Chr Cholecystitis
Of autopsy Pulm Emb.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Lusby M.D.
Address Fr. Sq. Hosp. Date signed 5/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

"PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 1775 — BALTIMORE CITY HEALTH DEPARTMENT — C 1775

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Homewood Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Hannah W. Frush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry S. Frush
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, , 1857

8. AGE: Years	Months	Days	If less than one day
87	--	--	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John J. Snyder
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary E. Hays
15. Birthplace Baltimore, Md.

16 (a) Informant Mary E. Frush
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Date received by registrar MAY 31 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to May 30 1944 and that I last saw him alive on May 29 1944

Immediate cause of death Myocarditis Arteriosclerosis — Duration Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Heady
Address 1403 Park Ave. Date signed 5/31/44

454284 C 1776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

572 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State GA (b) County
(c) City or town SAVANAH (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 43rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HANNAH LAMB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: DAVID

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 9-25-97

8. AGE: Years 46 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: SOLMON FAIRCLOTH
13. Birthplace: S.C.

MOTHER
14. Maiden Name: MINICE PIERCE
15. Birthplace: GA

16 (a) Informant: RECORDS
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory: Savannah
Location: Georgia

18 (a) Funeral director: William Cook Inc
(b) Address: 121 E. Saint Paul St

19 (a) (Signature of registrar) Huntington Williams, M.D. (b)

MAY 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 31 1944, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 15 1944, to MAY 31 1944, and that I last saw h&R alive on MAY 31 1944.

Immediate cause of death: BRAIN TUMOR - post operative. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/19/44

Major findings of operation: Basal tumor, Left Primary suppuration

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm W. Peters MD

Address: Johns Hopkins Hosp. Date signed 5/31/44

C 17717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17717

Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yeds.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Grace Buppert
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Harry Otto Buppert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16 1906

8. AGE: Years	Months	Days	If less than one day
38	1	14	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Saverio Guglielmini
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Barraca
15. Birthplace Italy

16 (a) Informant H. Otto Buppert
(b) Address 415 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Paul St

19 (a) Date rec'd by registrar MAY 31 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION 40

20. DATE OF DEATH May 30 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 1944 to 5-30 1944 and that I last saw her alive on 5-30 1944.

Immediate cause of death: Pulmonary edema — Duration
Due to: Cardiac failure
Due to: Hypertensive Cardio-Vasculor Renal Syndrome
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary thr., pleural path.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 5-30 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted] C 17718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17718 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 W Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 W Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo E Dougherty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-7-1863

8. AGE: Years 81 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas B. Dougherty
13. Birthplace Md

MOTHER
14. Maiden Name Annie E Shelf
15. Birthplace Ireland

16 (a) Informant Jas L Dougherty
(b) Address 1632 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Co Md

18 (a) Funeral director Roger A Feeley
(b) Address 1800 N Fayette St

19 (a) (Date received) Thurlington Williams, M.D. Registrar

MAY 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 - 1944, at 1.P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 - 1944 to May 30 1944, and that I last saw him alive on May 30 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson. M. D.
Address 3035 W. North ave Date May 31. 44

C 17719 HENRY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C 17719 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 253 S London Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 253 S London Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry A Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1882

8. AGE: Years 61 Months 7 Days 4 If less than one day hr. min.

9. Birthplace Laurel Del (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Alpheus Ellis

13. Birthplace Del

MOTHER 14. Maiden Name Sallie Henry

15. Birthplace Del

16 (a) Informant Mrs Margaret Ellis

(b) Address 253 S London Ave

17 (a) Burial (b) Date thereof 6-1-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebron Cem.

Location Hebron Md

18 (a) Funeral director George D Farley

(b) Address Fulton & Fayette

19 (a) (Date received) MAY 31 1944 (b) Registrar M Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 9.23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to May 30 1944. and that I last saw h. living on May 30 1944.

	Duration
Immediate cause of death Coronary Thrombosis	4 days
Due to Cardiac Vascular Disease	4 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W Johnson M. D.

Address 3432 Garden Ave Baltimore Md (Signed)

C 17720 ✓ C 17720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

13

3 (a) FULL NAME Benjamin F. Gawthrop

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race Wht. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Martha Gawthrop | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1845

8. AGE: Years 89 | Months 1 | Days 27 | If less than one day hr. min. 1855

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Paper Hanger

FATHER
12. Name Unknown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Louis Gawthrop
(b) Address 1927 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robt L. Tuttle
(b) Address 2700 Edmondson Ave

19 (a) (b)

JUN 1 1944 Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 31 1944 at 1.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1943 to May 31 1944 and that I last saw h alive on May 31 1944

Immediate cause of death: Chronic Myocarditis

	Duration
Due to	
Due to	
Other Conditions: Arteriosclerosis & Chronic Nephritis	study

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo Richardson
Address 12 W. 25th St Date signed May 31, 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17721 ✓ 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Cliftview Ave.
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Cliftview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT P. GRACE

3 (b) If veteran, name war
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife A. Katherine Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1862

8. AGE: Years	Months	Days	If less than one day
81	8	19	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Retired

FATHER
12. Name Daniel Grace
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Rebecca Proctor
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. R. P. Grace.
(b) Address 1514 Cliftview Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Rosenau Funeral Home
(b) Address 7401 Belair Road

19 (a) (Signature by registrant) (b) Address Huntington Williamsport, Md.

JUN 1 1944

VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31st, 1944 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8 1944 to May 31 1944, and that I last saw h/14 alive on May 29 1944.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to arteriosclerotic Heart Disease	Indefinite
Due to	
Other Conditions Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 5/31/44

C 1772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. C 1772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Diamond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 60 | Months | Days | If less than one day hr. min.

9. Birthplace Richmond Co. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Yerby
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15. Birthplace Va.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof June 3 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director O. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Huntington Williams, M.D.
(Registrar's signature) Registrar
JUN 1 1944

VS 101

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Uterus; metastases to the Lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentress M.D.
Medical Examiner.
Date signed May 23 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17723

BALTIMORE CITY HEALTH DEPARTMENT X ✓ C 17728

CERTIFICATE OF DEATH

55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Nottingham
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Hershour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 | 20 | 1933

8. AGE: Years 10 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Penroyl (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roy C. Hershour
13. Birthplace Penn

MOTHER
14. Maiden Name Lelia Swinehart
15. Birthplace Penn.

16 (a) Informant Mrs Roy C Hershour
(b) Address Nottingham Penn

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)
(c) Cemetery or crematory Nottingham Cem Co
Location [illegible] Penna

18 (a) Funeral director J. E. Lofton
(b) Address Kennett Square Pa.

19 (a) [illegible] (b) [illegible] Registrar

JUN 1 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 2 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944 to June 1 1944, and that I last saw him alive on May 31 1944.

Immediate cause of death: Respiratory failure — Duration

Due to: Cardiac failure

Due to: Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H Lofton M. D.
Address Union Memorial Hosp. Date signed 6/1/44

C 17724

321731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

C 17724

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Bree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	married

6 (b) Name of husband or wife Zebedee

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 5-1-70

8. AGE: Years	Months	Days	If less than one day
73	-	29	hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name John Devin

13. Birthplace Md

MOTHER 14. Maiden Name Rachael ?

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location A. A. County Md.

18 (a) Funeral director Mrs. Rotha A. Elwood

(b) Address 1129 N. Caroline St.

19 (a) (Signature of local registrar) (b) Registrar

JUN 1 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to May 30 1944 and that I last saw h-er alive on May 30 1944

Immediate cause of death Uraemia

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions Carcinoma Fundus of Uterus (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Lawrence Bube M. D.

Address The Johns Hopkins Hosp. Date signed 5-30-44

G 17725 ✓ G 17725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5357 Monmouth Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5357 Monmouth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. FIGGS

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Emma V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1855

8. AGE: Years 89 | Months 5 4 | Days — | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and State)

10. Usual Occupation Retired (Aged)

11. Industry or business

FATHER
12. Name Nelson Figgs
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Isaac S. Figgs
(b) Address 1413 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Pleasant
Location Balto. Co. Md.

18 (a) Funeral director Mr. Geo. A. Gutman
(b) Address 1735 Druid Hill Ave

19 (c) JUN 1 - 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 7 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Specify source of information of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 5-29-44

C 17726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 17726 ✓ Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2648 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2648 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Plitt

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27-1870

8. AGE: Years	Months	Days	If less than one day
74	4	4	hr. min.

9. Birthplace Balto. md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Lamb Butcher

FATHER
12. Name George Plitt
13. Birthplace Germany

MOTHER
14. Maiden Name Amalia Plitt
15. Birthplace Baltimore

16 (a) Informant Mrs Emma Plitt
(b) Address 2648 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Francis Cook-Lyfer
(b) Address 1600 W. North Ave.

19 (a) (Date received by Registrar) JUN 1 1944 (Registrar) Hamilton Mathias, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31- 1944 at 7.5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1944 to May 31 1944, and that I last saw h. alive on May 30 1944.

Immediate cause of death	Duration
Chr. Myocarditis	1 yr
Due to	
Due to Chr. Intestinal Nephritis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Brown M. D.
Address 1663 W. North Ave. Date signed 5/31

C 17727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

C 17727

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 122 N. Fremont ave

(c) Hospital or institution: Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 122 N. Fremont (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME George Wilson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife Viola Wilson

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 29 | Months ..... | Days ..... | If less than one day ..... hr. ..... min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Fairfield Drydock

FATHER — 12. Name Robert Wilson

FATHER — 13. Birthplace SC

MOTHER — 14. Maiden Name Annie Bell

MOTHER — 15. Birthplace SC

16 (a) Informant Viola Wilson

(b) Address 122 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)

(c) Cemetery or crematory .....

Location Wimsboro - S. C.

18 (a) Funeral director Ebony O. Wilson

(b) Address 1000 Brant Ave. Milwaukee, Wis.

19 (a) ..... (b) Huntington Registrar

JUN 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 31 - 1944 at 1125 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1944 to 5-31 1944; and that I last saw h[illegible] alive on 5-31 1944.

Immediate cause of death Pulmonary embolism — Duration .....

Due to perforated Gastric ulcer — Duration .....

Due to Dehiscence of abd wound — Duration .....

Due to Acute intestinal Dehiscence — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation May 11

Major findings of operation: Perforated Gastric ulcer

of autopsy: ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature M. E. Robertson M. D.

Address Univ. Hospital Date signed 5-31-44

C 17723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

172

C 17729

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Bethlehem Steel Co.
(c) Hospital or institution: Keyhighway

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Warren Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Arthur H. Keesey

3 (b) If veteran, name war

3 (c) Social Security Account No. 179-09-3984

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Miriam Hautz Keesey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 11/18/1906

8. AGE: Years 37 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace: Tower City, Pa.
(Town, county, and state)

10. Usual Occupation: Burner

11. Industry or business: Beth. Steel Corp.

FATHER
12. Name: Robert Keesey
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Bertha Miller
15. Birthplace: Pa.

16 (a) Informant: Mr. J. E. Dreisigacker
(b) Address: Tower City, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 1, 1944 (month) (day) (year)
(c) Cemetery or crematory: Tower City,
Location: Pa.

18 (a) Funeral director: Wm. J. Teckner & Sons
(b) Address: North & Pa. ave. Balt. Md

19 (a) (b)

JUN 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 19 44, at 9:15 M

21. I certify that I took charge of the remains described above, held an Inspection and Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-31-44 at 24/2 A P. M.
(b) Where did injury occur? Keyhighway - Bethlehem Steel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Fell down hold of ship.

23. Signature: Robert Lee Graham M.D.
Medical Examiner.
Date signed June 1 1944.

C 17729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C 17729

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3715 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3715 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL RAYMOND MELCHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-03-7597

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Valborg Melcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1884

8. AGE: Years	Months	Days	If less than one day
59	8	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Grain Inspector
11. Industry or business Chamber of Commerce

FATHER
12. Name John Melcher
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Nauman
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Valborg Melcher
(b) Address 3715 Cold Spring Lane 15

17 (a) Burial (b) Date thereof 6/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 1 - 1944 (b) Huntington Mills, Baltimore, Md.
VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 31, 1944, at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26-40 19 to 5-31 1944, and that I last saw h~~e~~r alive on 5-30 44 19.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to	
Due to Pelvis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Y. Warren M. D.
Address 2604 Garrison Blvd Date signed 6-1-44

C 17730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17730 X 123

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Dr. Robert F Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widower

6 (b) Name of husband or wife Anna R. Wells
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1866

8. AGE: Years	Months	Days	If less than one day
78	2	15	hr. ..... min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Richard Wells
13. Birthplace Md

MOTHER
14. Maiden Name Lafayette
15. Birthplace Md

16 (a) Informant A. Earle Wells
(b) Address Manchester Md.

17 (a) Burial (b) Date thereof 6/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Josephs
Location Govanstown, Md.

18 (a) Funeral director Le Quasdon
(b) Address Towsontown, Md.

19 (a) ..... (b) Huntington Williams, M.D.
(Date rec'd by registrar)

JUN 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 12:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to June 1 1944, and that I last saw him alive on May 31 1944

Immediate cause of death: Peritonitis — Duration .....
Due to: Gangrene of Cecum — .....
Due to ..... — .....
Other Conditions ..... — .....
(Include pregnancy within 3 months of death) — .....
Date of operation ..... — .....
Major findings of operation: ..... — .....
of autopsy: Same — .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature H. Clifton Rossberg, M.D.
Address St. Agnes Hosp. Date signed 6/1/44

C 17737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

C 17737

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 5 Carlton ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 5. Carlton ST
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Elizabeth T. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
F	C	widow

6 (b) Name of husband or wife Walter Brown

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			..... hr. ..... min.

9. Birthplace Middlesex Co. Va
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name William Thornton
13. Birthplace Middlesex Co Va

MOTHER
14. Maiden Name Lula Jones
15. Birthplace King + Queen Co Va

16 (a) Informant Yetty Thornton
(b) Address Cherrystone A.A. Co. Md

17 (a) Burial (b) Date thereof June 2, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location .....

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St
(c) Baltimore Md.
(Date rec'd by registrar)

JUN 1 - 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944, at 7 ?? M

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic
Cardiovascular disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed June 1st 1944

C 17732 C 17732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5212

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lafayette & John Streets
(c) Hospital or institution: Hospital for the Lesmen of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Temple Garden Apartment. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Madison Ave & Belvedere Dale Rd.

3 (a) FULL NAME Clara Cohn Hable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jacob Hable

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3 1876

8. AGE: Years 67 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace St. Louis Missouri (Town, county, and state)

10. Usual Occupation Prof.

11. Industry or business

FATHER 12. Name Wolfe Cohn
13. Birthplace Germany

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Norman M. Gross
(b) Address Temple Garden Apts. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balt. Hebrew
Location Balt. Md.

18 (a) Funeral director Levin Sondheim & Son
(b) Address 1902 Eutaw Place

(c) (Town clerk or registrar) (b) Hampton Williams, M.D. (Registrar)

JUN 1 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944 to May 31 1944 and that I last saw her alive on May 31 1944

Immediate cause of death: Cardio respiratory failure — Duration:

Due to Uremia — 5-7 da.

Due to Pyonephrosis

Other Conditions Septicemia & toxemia. Carcinoma, bladder

(Include pregnancy within 3 months of death)

Date of operation May 11, 1944

Major findings of operation: Carcinoma of bladder

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. McCord M. D.
Address Women's Hospital Date signed 5-31-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C 17733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Peach Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 1 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 1 1944 Huntington Williams M.D. (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1944, at 1 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Fraker M.D.
Medical Examiner.

Date signed May 17 1944

0983

C 17734 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 1340

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Bread
(c) Hospital or institution: Univ. Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 Wk 6 D.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Carroll
(c) City or town: Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Ralph O Feister

3 (b) If veteran, name war:
3 (c) Social Security Account No. 213-01-4676

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Evelyn L Thompson
6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec 28-1904

8. AGE: Years	Months	Days	If less than one day
39	5	3	hr. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Sawmill work

FATHER
12. Name: Arthur G Feister
13. Birthplace: Md

MOTHER
14. Maiden Name: Lucretia Shaffer
15. Birthplace: Md

16 (a) Informant: Mrs Ralph O Feister
(b) Address: Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3/44 (month) (day) (year)
(c) Cemetery or crematory: Hampstead
Location: Hampstead Md

18 (a) Funeral director: Edw C Upton
(b) Address: Hampstead Md

19 (a) Date received (year) (b) Registrar

JUN 1 1944

Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-1 1944, at 7:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1944 to 6-1 1944, and that I last saw him alive on 6-1 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Recurrent hemorrhage Sepsis, uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: Renal Calculus Rt.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: M E Robertson M. D.
Address: Univ Hosp. Date signed: 6-1-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 E

Registered No. 5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 E Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Shirley Calderwood

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-4-44

8. AGE: Years | Months: X1 | Days: 2927 | If less than one day hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Robert Calderwood
13. Birthplace: Pa

MOTHER 14. Maiden Name: Lena Berdal
15. Birthplace: Pa

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/1/44 (month) (day) (year)
(c) Cemetery or crematory: Brookville Cem
Location: Brookville Md

18 (a) Funeral director: Wm Cohen Inc
(b) Address: 124 [illegible] Paul St

19 (a) Filed 1944 (b) Registrar: Hamilton Williams, M.D.
(Filled by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944, to June 1 1944, and that I last saw h e alive on June 1 1944.

Immediate cause of death	Duration
~~Respiratory Failure~~ Cardiac failure	
Due to Uterus Pregnant	
Due to Congenital Heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1

Major findings of operation:

of autopsy: Congress.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye M. D.
Address JHH Date signed 6/1/44

G 17736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1637

Registered No. G 17736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Battery Ave (130) (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME ALICE V. C. GONDERMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-07-3687

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry Gonderman
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1894

8. AGE: Years	Months	Days	If less than one day
49 Y. M.	5	28	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Jacob Karn
13. Birthplace Germany

MOTHER
14. Maiden Name Anna R. Mirsching
15. Birthplace Baltimore, Md.

16 (a) Informant Henry Gonderman (Husband)
(b) Address 1224 Battery Ave, Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore, Cemetery (13)
Location Baltimore, Md.

18 (a) Funeral director J. Howard Evans
(b) Address 400 S. Charles St; Balto. 30, Md.

19 JUN 1 - 1944 (date rec'd by Registrar) (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, Lobular

Due to Creosote poisoning

Other Conditions Lacerations, left wrist
mental despondency
(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-25-44 M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury swallowed creosote

23. Signature H. L. Wallenweber M.D.
Asst. Medical Examiner.
Date signed 5-30-44

G 17737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 17737
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Calvert & Saratoga Sts.
(b) Street address Mercy Hospital
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Otha Seal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Married

6 (b) Name of husband or wife Hubert Seal
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) July 26, 1919

8. AGE: Years	Months	Days	If less than one day
24 25 yrs.	10	4 5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business - Home

FATHER
12. Name Dow Arnold
13. Birthplace Tennessee

MOTHER
14. Maiden Name Laura Givens
15. Birthplace Tennessee

16 (a) Informant Hubert Seal
(b) Address Elkaton, Maryland.

17 (a) Removal to Burial thereof 6-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Lincoln Penna

18 (a) Funeral director H. C. Heimbolton
(b) Address Ellicott City Md

19 JUN 2 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944 to June 1 1944, and that I last saw h[er] alive on June 1 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Cardio-Vascular Hypertensive disease	
Due to Nephritis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Ellsworth Cook Jr. M. D.
Address Mercy Hospital Date signed June 1944.

G 17738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G 17738 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4903 Crowson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna C. Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband: William Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13th 1867

8. AGE: Years 74 | Months 11 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Unknown
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary
15. Birthplace: Unknown

16 (a) Informant: Albert P. Tucker
(b) Address: 4903 Crowson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory: Balto
Location: " Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) JUN 2 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1944, at 11:40 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest. Compound comminuted fracture right leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: (a) Date of injury May 31st 1944 M. (b) Where did injury occur? 4903 Crowson Ave (c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No (d) Means of injury Fell from roof.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed May 31, 1944.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

V G 17739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 N Stockton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson Briscoe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Aug 25, 1901
8. AGE: Years 42 Months 9 Days 6 If less than one day hr. min.
9. Birthplace Betts Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Abraham Briscoe
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Moulden
15. Birthplace Maryland

16 (a) Informant Laura Briscoe
(b) Address 524 N Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Md
18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) JUN 2 - 1944 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1944 to 5/31 1944 and that I last saw him alive on 5/30/44

Immediate cause of death Pulmonary Tuberculosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. P. Howell M. D.
Address 600 N Carrollton Ave Date signed 6/1/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No. G 17740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 Prestman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Prestman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Queenie Anderson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 18, 1900

8. AGE: Years	Months	Days	If less than one day
43	8	12	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Tinsley Anderson
13. Birthplace Va

MOTHER
14. Maiden Name Lenhoom
15. Birthplace Va.

16 (a) Informant Queenie Anderson
(b) Address 601 Prestman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-14 (month) (day) (year)
(c) Cemetery or crematory Steelton Pa
Location Pa

18 (a) Funeral director George H. Kelson
(b) Address 1303 Prestman St

19 (a) 6-2-1944 (Date received by Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on May 30 1944.

Immediate cause of death	Duration
Cardio Vascular Disease	6 mos
Due to Broken Compensation	4 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emilliam Frey M.D.
Address 1938 Pa Ave Date signed 6/1/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

V G 17741 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Sister Humiliata Frye O.S.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1867

8. AGE: Years 77 | Months 2 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Mother M. Teresa O.S.P.

(b) Address 501 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery

Location

18 (a) Funeral director Mrs. Coles A. Elliott & Daughter

(b) Address 2129 N. Caroline St.

19 (a) ... (Date received by Registrar) (b) Huntington Williams, M.D.

JUN 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31st 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944, to May 31st 1944, and that I last saw h.er alive on May 31st 1944

Immediate cause of death: Myocardial Insufficiency — Duration: 6 months

Due to: Arteriosclerosis — 5 years

Due to: Hypertension — 5 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: No.

Major findings of operation:

of autopsy: No.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Schaefer M. D.

Address 600 E. Cold St Date signed June 1st 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BG 1742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 1742

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Redwood

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 323 E. 25th St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MAY Mrs. Ida Frances

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lawrence H. Francis

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec. 15th 1882

8. AGE: Years 61 Months 5 Days 17 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name Edwin F. Ebberts

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Christina B. Schaefer

15. Birthplace Balto. Md.

16 (a) Informant Lawrence H. Francis

(b) Address 323 E 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (month) 3 (day) 44 (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Jno. Waters & Son

(b) Address 2503 Edmondson Ave

19 JUN 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 · 1 19 44 at 1:07 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5·27 19 44 to 6·1 19 44 and that I last saw h 44 alive on 6·1 19 44.

	Duration
Immediate cause of death: Respiration Ceased	
Due to: Hypostatic pneumonia	
Due to: Sub-arachnoid hemorrhage	
Other Conditions: Diabetis Mellitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. Rinehart M. D.

Address University Hosp. Date signed 6·1·44

17743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 17743 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lafayette Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugenia Tubman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1864

8. AGE: Years	Months	Days	If less than one day
80	-	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William H. T. Johnston
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Lloyd
15. Birthplace Md.

16 (a) Informant Mrs Gertrude R. Johnson
(b) Address 1302 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 Filed JUN 2 - 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1944 19 , at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1944 to 5/30/44 and that I last saw her alive on 5/29/44

Immediate cause of death

Due to Pulmonary Hemorrhage

Due to Hypertensive

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Eldridge Dowe M. D.
Address 1131 Harlem Date signed 6/1/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-8827 G 17744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G 17744 Registered No. 12/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 12 Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7102 Fait Ave-(Baltimore Co.) (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Wylie C. Webb
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Anna (D)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 9-1868
8. AGE: Years 76 Months 4 Days 12 22 If less than one day ..... hr. ..... min.
9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Webb (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Frances ? (D)
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals Records
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd A.A.Co.
18 (a) Funeral director Earl L. Tgess
(b) Address 715 Light St.
19 (a) ..... (b) ..... (Date rec'd by registrar) MAY 2-1944 Williams, Md. Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/ 1944 at 11:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1944 to 5/4 1944 and that I last saw h[illegible] alive on 5/31 1944.

Immediate cause of death	Duration
Uremia	?
Due to Nephrosclerosis	?
Due to Arteriosclerotic heart disease & failure	?

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. Hect
Address ..... Date signed M 5 D. 5/3/44

G 17745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G 17745 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 E Montgomery St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fredericka Erhardt
6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Aug. 21st 1855

8. AGE: Years	Months	Days	If less than one day
88	9	9	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Bradt
15. Birthplace Md.

16 (a) Informant Mrs Robert Mitchell
(b) Address 602 Stoneleigh Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave

18 (a) Funeral director Carl L. Haess
(b) Address 715 Light St.

19 (a) (Date received by registrar) JUN 2 - 1944 Thurston Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 1944 at 1:22 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1944 to 5/30 1944 and that I last saw him alive on 5/29 1944.

	Duration
Immediate cause of death Cardiac Thrombosis	3 days
Due to Senile Myocardiosis	1 year
Due to Arteriosclerosis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Van Ness Randall M.D. Date signed 7/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 17746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G 17746 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 E. Balto. St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Kovler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Flavor Extractor

11. Industry or business

FATHER
12. Name Nathan —
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael —
15. Birthplace Russia

16. (a) Informant Annie Kovler
(b) Address 2302 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Pheins Inc
(b) Address 1739 E. Balto St

19 (a) JUN 2 - 1944 (Registrar's signature) Huntington Millhauser M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944 at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31 1944 to 6/1 1944, and that I last saw him alive on 6/1 1944.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Atelectasis - entire Left Lung	
Due to Ca Pulmonale - Left Lung resection	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis - Ca Pulmonale

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23, Signature H. Pheins M. D.

Address Sinai Hosp. Date signed

G 1747 ✓ G 1747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2628 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Ida GERSUK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Moses

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Daniel Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Isadore Gersuk
(b) Address 2927 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) JUN 2 1944 (Registrar's signature) Hampton Williams, M.D.
(b) Date Registered
VS 180

MEDICAL CERTIFICATION 59

20. DATE OF DEATH 6-1-44 19 ..., at 10 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 43 to June 1 19 44 and that I last saw h.. alive on May 28 19 44

Immediate cause of death: Femoral & Cerebral Arteriosclerosis — Duration: Years

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Hampton Williams M.D.
Address 2904 Rusot Rd Date signed 6/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 17748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 Whatcoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d 16
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Whatcoat St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Forrest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Sherman Forrest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1890

8. AGE: Years 53 | Months 6 | Days 23 | If less than one day ___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Leighman Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Georgiana Peters
15. Birthplace Md.

16 (a) Informant Jennie Davis
(b) Address 522 N Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Mt-Wilson

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Dekalb St

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

JUN 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19XX at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 19XX to May 30 19XX, and that I last saw her alive on May 30 19XX

Immediate cause of death: Lobar Pneumonia — Duration: 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Williams Frey, M. D.
Address 1928 Pa Ave Date signed 6/1/44

G 17749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 17749

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits write RURAL and give town)
(d) Street No. 7122 North Ave Arbutus (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Bloecher

3 (b) If veteran, name war — none
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jennie Bloecher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1874

8. AGE: Years 70 | Months 3 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Butcher
11. Industry or business

FATHER
12. Name Ludwig Bloecher
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Bloecher
15. Birthplace Germany

16 (a) Informant Wm. H. Bloecher
(b) Address 1313 Forest Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3. 1937 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) [illegible] (b) Huntington Mills, Md.

JUN 2 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1937 at 7:15 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 1, 1937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADA ISABEL GUNTS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1890

8. AGE: Years	Months	Days	If less than one day
54	3	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Registered Nurse
11. Industry or business

FATHER
12. Name J. Walter Gunts
13. Birthplace New York

MOTHER
14. Maiden Name Dora Miller
15. Birthplace Balto.

16 (a) Informant Mrs. Anna Orn
(b) Address 2706 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) JUN 2 1944 Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1944, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 5/31 1944, and that I last saw h[illegible] alive on 5/31 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hours
Due to	
Due to	
Other Conditions Hypertension	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Mitchell M. D.
Address 24 E. Preston St. Date signed 6/1/44

G 17751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193E

G 17751 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:

15-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4031 Bonner Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LURENA ARMELING MOORE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel H. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1880

8. AGE: Years 64 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Armeling, Jr.
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Kimpel
15. Birthplace Balto., Md.

16 (a) Informant Mr. George K. Armeling
(b) Address 4031 Bonner Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 2 1944 (Registered by register) (b) Huntington Mills, Md.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 31, 1944, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1944 to 5/31 1944, and that I last saw him alive on 5/31 1944.

	Duration
Immediate cause of death: Pulmonary oedema	36 hrs
Due to: Myocardial insufficiency	?
Due to: Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.
Address 1004 Linden Ave Date signed 6/1/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17752 G 17752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lombard & Green
(b) Street address 1532 Sheffield Rd.
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 2 7 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Sheffield Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Z. Chas Ebaugh

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-07-2862

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Alice Hart Ebaugh
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Field Insp.

11. Industry or business Canning Business

FATHER
12. Name Zachariah Cornelius Ebaugh
13. Birthplace Carroll County Md

MOTHER
14. Maiden Name Elizabeth Bell Gosford
15. Birthplace Baltimore County Md

16 (a) Informant Minnie Ebaugh
(b) Address 3703 Sequoia Ave, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Wm Bergman & Sons
(b) Address Reisterstown Md

19 (a) (Date received by registrar) JUN 2-1944 Humbert Williams, M.D. (b) Address Univ Hosp. Date signed 5-31-44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 19 44 to 5-31 19 44, and that I last saw him alive on 5-31 19 44.

Immediate cause of death: Pulmonary Embolism — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-23-44

Major findings of operation: acute cholecystitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E R Iverson M. D.
Address Univ Hosp. Date signed 5-31-44

G 17753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

Registered No. G 17753

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give exact place of death and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 10 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 253 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Joseph Murphy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Murphy

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 16, 1916

8. AGE: Years 27 yrs. Months 11 Days 14 If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethl. Steel Co

FATHER
12. Name Joseph Murphy
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Anna Watkins
15. Birthplace S. Carolina

16 (a) Informant Mrs. Joseph Murphy
(b) Address 253 N. Exeter St.

17 (a) Burial (b) Date thereof 6/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Leroy O. Wilson
(b) Address 1000 Frankford Ave

19 (Filed by registrar) JUN 2 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944, at 6.57 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to May 30 1944, and that I last saw him alive on May 30 1944

Immediate cause of death Cardiac failure — Duration ?

Due to Pneumonia bilateral type 24 — 8 days.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: Bilateral Lobar Pneumonia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Davis, Jr., M.D.

Address Mercy Hospital Date signed 5/31/44

G 17754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17754 Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 S Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1616 S Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Bell Ward

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Oliver B
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 1 1880
8. AGE: Years 64 | Months 1 | Days 30 | If less than one day: hr. min.
9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Wm Boyd
13. Birthplace Md

MOTHER
14. Maiden Name Mary P. Dalrymple
15. Birthplace Md

16 (a) Informant Mrs. Oliver B Ward
(b) Address 1616 S Charles St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial Park
Location Washington Blvd
18 (a) Funeral director William H Mareck
(b) Address 716 Lig at St
19 (a) JUN 2 - 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944, at 5:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/12/44 19 , to 5/31/ 19 44 and that I last saw him alive on 5/30/ 19 44.

Immediate cause of death	Duration
Hypertensive cardio vascular disease	5 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 6/1/44

G 17755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17755 Registered No. 4812

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations. Do not leave any blanks. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911-E. Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911-E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Hook KEARNS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James E. Kearns

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) April 28-1873

8. AGE: Years 71 Months 1 Days 8 If less than one day hr. min.

9. Birthplace Balto. Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Hook
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Kate Azure
15. Birthplace County Cork, Ireland

16 (a) Informant James E. Kearns
(b) Address 1911-E. Oliger St.

17 Burial (Burial, cremation, or removal) (b) Date thereof June 3-44 (month) (day) (year)

(c) Cemetery or crematory Mount Carmel
Location Old Frederick Rd.

18 (a) Funeral director John A. Hogan
(b) Address 3002 E. Balto. St.

19 (a) Filed June 2 1944 (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944 at 7.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 24 1944 to May 31 1944, and that I last saw him alive on May 30 1944

Immediate cause of death Cachexia and metastasis — Duration 2 weeks

Due to Carcinoma of Uterus — 1 year

Due to

Other Conditions Chronic Interstitial Nephritis — 3 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Greenberg, M.D.
Address 2075 E. North Ave. Date signed 6/1/44

G 17756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 17756 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Cumberland St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Cumberland St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stephens

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 5/27/44

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: 1 hr. 53 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Frederick Edmund Stephens
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Marion Elizabeth Shipley
15. Birthplace Baltimore Maryland

16 (a) Informant Marion Stephens
(b) Address 607 Cumberland St

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAY 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 2 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1944 at 5:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1944 to 5/27 1944, and that I last saw him alive on 5/27 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity (315.4)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas B. Dewees M.D.
Address Univ. Hosp. Date signed 6/2/44

VS 8

10980

G 17757 453628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 17757 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 908 Shuter (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Braddie Jeffress

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-03

8. AGE: Years 41 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace VA (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name John Jeffress

13. Birthplace VA

14. Maiden Name Julia Lyle

15. Birthplace VA

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL MAY 29 1944

18 (a) Funeral director Commissioner of Health

(b) Address

JUN 2 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

0979

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1944, at 10 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 3 1944 to MAY 22 1944, and that I last saw him alive on MAY 22 1944

Immediate cause of death	Duration
Cerebral thrombosis	
Due to undetermined type	2 yrs
Due to glomerulonephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huntington Williams M. D.

Address Johns Hopkins Hospital Date signed 5-29-44

G 17758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1307

G 17758 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 Lemmon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife Stansbury Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1886

8. AGE: Years	Months	Days	If less than one day
57	7	1	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Chase
13. Birthplace md

MOTHER
14. Maiden Name Margaret Chase
15. Birthplace md

16 (a) Informant Cora Long
(b) Address 1045 W. Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George A. Jackson
(b) Address 1303 Pressman St

19 (a) (Date received by registrar) JUN 2 - 1944 Registrar Huntington Williams, M.D.

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1944, at 7 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1944, to May 30 1944, and that I last saw h[illegible] alive on May 30 1944.

Immediate cause of death

	Duration
Aneurysm of the Ascending Aorta	
Due to Aortitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Aortic Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Burgess M.D.
Address Provident Hospital Date signed 6/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17759 — BALTIMORE CITY HEALTH DEPARTMENT — G 17759

CERTIFICATE OF DEATH

938 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hopkins Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town none
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Grace B. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Edwin W. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Burkhardt
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edwin W. Adams, Jr.
(b) Address 614 St. Johns Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John A. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 2 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1944 to 5/31 1944, and that I last saw h. alive on 5/31 1944

Immediate cause of death	Duration
Coronary Thrombosis	Unknown
Due to Hypertension	Unknown
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas R. Goldborough M. D.
Address 2923 St. Paul St. Date signed 6/1/44

D17760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 17760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4129 Roland Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4129 Roland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Powel Byrd Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen Parsons
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 31, 1859

8. AGE: Years	Months	Days	If less than one day
85	--	--	hr. min.

9. Birthplace Bloucester Co., Va. (Town, county, and state)
10. Usual Occupation Traffic Mgr., Old Bay Line
11. Industry or business RETIRED

FATHER
12. Name Tazewell Thompson
13. Birthplace Va.

MOTHER
14. Maiden Name Susan Lewis Byrd
15. Birthplace Va.

16 (a) Informant Mrs. H. P. Thompson
(b) Address 4129 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by local registrar) JUN 2 1944 Registrar
VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Dec 1943, to 31 May 1944, and that I last saw alive on 31 May 1944.

Immediate cause of death Carcinoma - Duodenum & Pancreas

Due to Morbid Nutritional Disturbance

Secondary Anemia.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 15 mos?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Packard M. D.
Address 2925 N. Charles St. Date signed

Huntington Mitchell, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17761 Registered No. 48B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 E Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos, 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lambardy Apt. Stoney Run (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. J. BOSLEY THOMAS (MARGUERITE M.)

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mr. J. Bosley Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 17 May 1885

8. AGE: Years 56 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Mr. Louis P. Maas
13. Birthplace Virginia

MOTHER 14. Maiden Name Gladys George
15. Birthplace Baltimore

16 (a) Informant Husband
(b) Address Lambardy Apt., Stoney Run Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (b) JUN 2 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 May 1944, at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Jan. 1944 to 31 May 1944, and that I last saw h. alive on 31 May 1944.

Immediate cause of death Cardio vasc. failure — Duration

Due to Generalized metastatic carcinoma — 3½ yrs.

Due to Carcinoma of uterus — 4 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Stephen J. Van Dell III M. D.
Address Union Memorial Hosp. Date signed 5-31-44

G 17762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 927

G 17762 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D of A Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville RURAL (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Hillside Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G. Faber

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-5094

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1876

8. AGE: Years	Months	Days	If less than one day
67	0	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Machine shop.

FATHER
12. Name Henry Faber
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Herr
15. Birthplace Balto. Md.

16 (a) Informant Robert P. Faber
(b) Address 16 Hillside Rd. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 461 Ch. St.

19 (a) JUN 2 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 1944, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Degenerative Myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McNabb M.D.
Medical Examiner.
Date signed 6/1/44

G 17763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

G 17763 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 W. West St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 W. West St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Austin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. Austin

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1887

8. AGE: Years 57 | Months 4 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Nathaniel Thomas
FATHER 13. Birthplace A. A County Md.

MOTHER 14. Maiden Name Adeline Massey
MOTHER 15. Birthplace Wilmington Del.

16 (a) Informant Maude Dixon
(b) Address 115 Winter St.

17 (a) ... (Burial, cremation, or removal) (b) Date thereof 6 2 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemty
Location Balto. Md.

18 (a) Funeral director Walter B. Scriggs
(b) Address 1818 Hamburg Street

19 (a) JUN 2 - 1944 (b) ...
Filed by registrar ... Hampton Williams, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 1944 at 1030 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to May 29 1944.
and that I last saw her alive on May 28 1944

Immediate cause of death: Acute Myocarditis — Duration 6 mo 1 d
Due to Unknown
Due to ...
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
... of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature John W. Gaines M. D.
Address 665 W. Barre Date signed 6/1/44

G 17705-4286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 571 Registered No. G 17764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Morgantown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Payton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Alfred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-08

8. AGE: Years	Months	Days	If less than one day
36	-	21	hr. min.

9. Birthplace Ky (Town, county, and state)

10. Usual Occupation Housewife -

11. Industry or business

FATHER
12. Name Oscar Hayden -
13. Birthplace Ky

MOTHER
14. Maiden Name Sarah Pritchard
15. Birthplace Ky

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year).
(c) Cemetery or crematory
Location Morgantown, W. Va.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Pl.

19 JUN 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944 4:44 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to June 1 1944 and that I last saw her alive on June 1, 1944

Immediate cause of death Pituitary tumor - post operative

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/12/44

Major findings of operation: Pituitary tumor

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lew Crawford M.D.

Address Johns Hopkins Hosp. Date signed 6/1/44

G 17765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G 17765 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 5 N
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 N. Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F Obrigkeit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Carmela Bonomo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1905

8. AGE: Years	Months	Days	If less than one day
39	1	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Glen L. Martin

FATHER
12. Name George Obrigkeit
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Paul
15. Birthplace Germany

16 (a) Informant Wife, Carmela Obrigkeit
(b) Address 430 N. Exeter Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pepitone
(b) Address 2818 E. Baltimore St.

19 Received JUN 2 1944 Registrar

VS 151

MEDICAL CERTIFICATION 55

20. DATE OF DEATH June 1 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: Coroner's Case No. 55
(a) Date of injury May 26 1944 4 P.M.
(b) Where did injury occur? Eastern Ave & Langley Road
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Collision of auto & motorcycle

23. Signature Robert H. Lee Graham M.D.
Medical Examiner.
Date signed June 1 1944

G 17766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 17766

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address 3239 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3239 Clifton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Pearce Dechter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel Dechter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th 1884

8. AGE: Years	Months	Days	If less than one day
59	11	23	hr. min.

9. Birthplace Parkton Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Pearce
13. Birthplace Delta Hall Md.

MOTHER
14. Maiden Name Hannah Price
15. Birthplace Forestor Md.

16 (a) Informant Dr Walter Tibbett
(b) Address 3220 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3-44 (month) (day) (year)
(c) Cemetery or crematory Forest Baptist Cem
Location Forestor, Balto Co Md

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1932 W. Fayette Ave

19 (a) JUN 2 - 1944 (Date received by registrar) Thurlington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June May 31 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1936 to May 31 1944 and that I last saw h-- alive on May 31 1944.

Immediate cause of death	Duration
(a) Myocarditis	about 1 yr.
Due to (b) advanced arterio sclerosis	
Due to (c)	
Other Conditions Osteo myelitis of spine	about 6 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury ~~occur about home, on~~ farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Tibbett M. D.
Address 3220 Garrison Blvd Date signed June 2/44

G 1776?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 1776?

50

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 ANDOVER ROAD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Sendelbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JOHN SENDELBACH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	8	4		

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name FREDERICK FREIMANN
13. Birthplace GERMANY

MOTHER
14. Maiden Name Elizabeth Gebhardt
15. Birthplace GERMANY

16 (a) Informant Miss MARGARET SENDELBACH
(b) Address 1110 ANDOVER ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 3 1944 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 18 W. Mt. Royal Ave

19 (a) JUN 2 1944 (Date rec'd by registrar) Registrar Mildred Mitchell

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1944, at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 1944, to 5/31 1944, and that I last saw h.er alive on 5/31 1944.

Immediate cause of death	Duration
Carcinoma of cervix metastasis	unknown
Due to Carcinoma of breast-rt.	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Kemper M. D.
Address University Hosp. Date signed 6/1/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17768 78891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17768 Registered No. 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Glos

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1880

8. AGE: Years 63 | Months 9 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Glos
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Gunzel
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery or crematory Covered Heart Cem
Location Fernandale Rd Balto Co

18 (a) Funeral director Geo Lahy Sons
(b) Address 3 E Eight St

19 (a) Filed by Thurlington Williamsport

JUN 2 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 1944 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1942 to 5-26 1944, and that I last saw him alive on 5-26 1944.

Immediate cause of death: Pulmonary tuber — anosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration: 8 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattman M. D.
Address B.C.H Date signed 6-1-44

G 17769 — BALTIMORE CITY HEALTH DEPARTMENT — G 17760 — Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as completely as possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Kimble Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Kimble Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles W. Hindle

3 (b) If veteran, name war none

3 (c) Social Security Account No. 218-09-2215

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1871

8. AGE: Years 72 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Brush Maker

11. Industry or business

FATHER 12. Name T.

13. Birthplace England

MOTHER 14. Maiden Name Mary Ann Carr

15. Birthplace England

16 (a) Informant Mrs Mary Fowler

(b) Address 3711 Kimble Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Rd

18 (a) Funeral director S. Walter Mayo

(b) Address 619 N. Bouldin St.

19 JUN 2 1944 (b) Huntington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 May 1944 to 1 June 1944 and that I last saw h[illegible] alive on 1 June 1944

Immediate cause of death	Duration
Pneumonia	8 days
Due to arterio-sclerosis	6 yrs
Due to arterio sclerosis Cerebr. Hemm	6 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation X
Major findings of operation: X
of autopsy: X

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm E Hooper M.D.
Address 3534 Ellerslie Ave Date signed 2 June 44

VS 3

G 1777D ✓ G 1777D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 N Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N Chester (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H Plummer Plumer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Plummer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1860

8. AGE: Years	Months	Days	If less than one day
84	3	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Engineer Penn RR
11. Industry or business

FATHER
12. Name John Plumer
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Mrs Mary Plummer
(b) Address 719 N Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) JUN 2 1944 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944 at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1942 to May 31 1944. and that I last saw him alive on May 31 1944.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to Senile Psychosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pakorny M. D.
Address 2200 E Madison St Date signed 6/2/44

G 17771 ✓G 17771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Paulaski
(c) Hospital or institution Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N Monroe st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina E Hogan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 1900

8. AGE: Years 43 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Bath Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bank

FATHER
12. Name Michael J Hogan
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie J Miller
15. Birthplace Olney

16 (a) Informant Annie J Hogan
(b) Address 15 N Monroe st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-44 (month) (day) (year)
(c) Cemetery or crematory Carlo Dal
Location Baltimore Md

18 (a) Funeral director George G Farley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 19 44, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31/19 44, to 5/31/19 44, and that I last saw h.e.r alive on 5/31/19 44.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Anton Jr. M.D.
Address Bon Secours Hosp. Date signed 6/31/44

G 17772 BALTIMORE CITY HEALTH DEPARTMENT G 17772
CERTIFICATE OF DEATH
83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3037 Mayfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 MayBerry Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Barbara Pazourek

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Charles W.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 29, 1877

8. AGE: Years	Months	Days	If less than one day
67	1	1	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER 12. Name Mathew Worhna
13. Birthplace Czec

MOTHER 14. Maiden Name Vodak
15. Birthplace Czec

16 (a) Informant Julia M. Vasilo-daughter
(b) Address 3037 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison St.

19 (a) (Date received) JUN 2 1944 (b) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH 5/30/44 19 at 1:10 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 19 44 to May 30 19 44 and that I last saw h alive on May 29 19 44

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 hours
Due to: Arteriosclerosis — Duration: 1 yr
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. Gary MD
Address 6111 Newark Ave Date signed 5/31/44 M.D.

G 17773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17773

Registered No. 46 D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore
(c) Hospital or institution: 6202 Eldwanta Rd

(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montg omery
(c) City or town Richerson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Clara Hott.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Richard B Hott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1874

8. AGE: Years	Months	Days	If less than one day
69	6	27	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thos McDonald.
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary Dailey
15. Birthplace N.Y.

16 (a) Informant R B Hott
(b) Address Dickerson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-44 (month) (day) (year)
(c) Cemetery or crematory Monocacy
Location Braddeville, Md

18 (a) Funeral director W. J. Helton
(b) Address Barnesville, Md

19 (a) (Date received by registrar) (b) Registrar

JUN 2 VS 1944

Hampton McKenzie, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944, to June 2 1944, and that I last saw her alive on June 1 1944.

Immediate cause of death	Duration
Adeno Carcinoma of Rectum	?
Abdominal Uremia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clement H Geiser M. D.
Address 511 Pennsylvania Ave Date signed 6-2-44

G 1777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 1777

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Forrest Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Paoli

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-03-7366

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1 1886

8. AGE: Years 58 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace PITIGLIANO ITALY
(Town, county, and state)

10. Usual Occupation DISH WASHER

11. Industry or business LUNCH ROOM ?

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant
(b) Address

17 (a) H Burial (b) Date thereof June 3/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Marley St

19 (a) JUN 3 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 2:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollamaker M.D.
Medical Examiner.
Date signed June 2, 1944.

G 17775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G 17775

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 W. Mulberry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George H. Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: Mattie Mathews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1889

8. AGE: Years 54 | Months 7 | Days 19 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Thimbler V. Matthews
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice R. McLernan
15. Birthplace Baltimore Md

16 (a) Informant William Mat. Matthews
(b) Address 309 Fauhill Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director William Lash, Inc.
(b) Address 1317 St. Paul St.

19 JUN 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at 8:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushing by train

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20-2

(a) Date of injury 6-2-44 at 8 A. M.
(b) Where did injury occur? Ca. P.R. Track - Franklin St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes.
(d) Means of injury Struck by train.

23. Signature H. L. Wolbarsht M.D. (Deputy) Medical Examiner.
Date signed June 2, 1944

VS 151

G 17776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G 17776

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Kentucky Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Kentucky Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert C. Rebhun (REBHUN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife Marie Rebhun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1859

8. AGE: Years 84 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Wurtemburg Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Butcher

FATHER
12. Name (Unknown) Rebhun
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Marie Gunter
(b) Address 3016 Kentucky Ave

17 (a) Burial (b) Date thereof 6/3/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUN 2 - 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 10:30 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro sclerotic
cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fortune M.D.
Medical Examiner.
Date signed June 1 1944.

1777 BALTIMORE CITY HEALTH DEPARTMENT G 1777
CERTIFICATE OF DEATH 176 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure to give correct age in years. Where the exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2630 Kirk Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ulrich H. McCleary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | ~~Separated~~ married, ~~widowed or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Mildred McCleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30th 1901

8. AGE: Years 42 | Months 9 | Days 2 | If less than one day ___ hr. ___ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Boatsman

11. Industry or business B & O R.R.

FATHER 12. Name Harry McCleary
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Ella Davis
15. Birthplace Balto. Md.

16 (a) Informant Harry McCleary
(b) Address 618 W. 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JUN 3 - 1944 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushing of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 9/8
(a) Date of injury 6-2-44 at 8 A. M.
(b) Where did injury occur? 7 E. 25th St. Sunshine Biscuit Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Hook While at work? Yes
(d) Means of injury Fell down elevator shaft.

23. Signature H. L. Wallingmaier M.D. Medical Examiner.
Date signed June 2, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WKG 17773 ✓ G 17773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Devereaux St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Rexmere Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Maud Shue

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband William H. Shue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1886

8. AGE: Years	Months	Days	If less than one day
57	7	24	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Alfred Ward
13. Birthplace Md

MOTHER
14. Maiden Name Mary T. Barnes
15. Birthplace Md.

16 (a) Informant Isabel Paterson
(b) Address 510 E. 39th St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/4/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hampstead
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

JUN 3 - 1944 (Date rec'd by Local Registrar) (b) Huntington Mills, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1944, to 19, and that I last saw h[er] alive on May 30 19 44

Immediate cause of death: Carcinoma of Cervix — Duration: Indefinite

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Chas. L. Goodbrough M. D.
Address 2923 St Paul St Date signed 6/2/44

G 17779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

482 Registered No. G 17779

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison st
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna C. Hitaffer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Abby G. L. Hitaffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 about 1873

8. AGE: Years	Months	Days	If less than one day
about 70	9	5	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name George Burns
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget (Unknown)
15. Birthplace Ireland

16 (a) Informant Mrs Nancy Rogers
(b) Address 2140 Brookfield ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St

19 (Date received by registrar) JUN 3 - 1944 Thurlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1944, at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to June 2 1944, and that I last saw h~~er~~ alive on June 1 1944.

Immediate cause of death	Duration
Carcinoma Thrombosis.	
Due to Carcinoma Liver with metastasis	
Due to of liver & lungs.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. S. French M. D.
Address 2329 Arunah ave Date signed 6/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~C 17780~~ BALTIMORE CITY HEALTH DEPARTMENT C 17780

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Rossiter Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Rossiter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

10

3 (a) FULL NAME James T. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 2 1863

8. AGE: Years	Months	Days	If less than one day
81	2	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business Hopper McGaw Co.

FATHER
12. Name Henry Moore
13. Birthplace Unknown

MOTHER
14. Maiden Name Martha "
15. Birthplace "

16 (a) Informant Mrs. Geo. Kuefely
(b) Address 505 Rossiter Ave

17 (a) Burial (b) Date thereof 6/2/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JUN 3 - 1944 Huntington Williams, M.D.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1944 at 6 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to June 1 1944 and that I last saw h[illegible] alive on May 31 1944

Immediate cause of death
Due to Bronchial Pneumonia — Duration 2 Days
Due to Old age
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? X X
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify (yes or no) place)
(e) Means of injury
23. Signature R. L. Keyser M. D.
Address Westwood Apts. Date signed 6-2-44

1781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 1781 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Brooks Lane.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Georgian Court Apts.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ROSE E. GOMPRECHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sigmund Gomprecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1874

8. AGE: Years 69 | Months 7 6 | Days | If less than one day hr. min.

9. Birthplace New York.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Abraham Goodman.
13. Birthplace Germany.

MOTHER
14. Maiden Name Bessie Cohen.
15. Birthplace Germany.

16 (a) Informant Mr. B. Lutzky.
(b) Address Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/44. (month) (day) (year)
(c) Cemetery Chab Shaâom Cem.
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) [illegible] 1944 (b) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1928 to June 1 1944, and that I last saw h[illegible] alive on June 1 1944.

Immediate cause of death	Duration
myocardial insufficiency	2 yrs.
Due to	
Due to Hypertension	6 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1720 Eutaw Place. Date signed 6/2/44

G 17682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 17682

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Roslyn Ave
(c) Hospital or institution: Md. General Hosp. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Roslyn Ave. (Rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. E. Miller

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) ~~Single~~, married, ~~widowed~~ or divorced. ~~Married~~

6 (b) Name of husband or wife: Edna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1873

8. AGE: Years 70 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Fidelity Deposit Co.

FATHER
12. Name George W. Miller
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace Carroll Co. Md.

16 (a) Informant Mary F. Miller
(b) Address 2206 Roslyn Ave. Balto

17 (a) Burial (b) Date thereof 6/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director WM. H. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by registrar) (Registrar)

VS JUN 3 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1/1944, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1944 to 6/1 1944 and that I last saw h.[illegible] alive on 6/1 1944.

Immediate cause of death: Coronary thrombosis — Duration:

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Myers M.D.
Address 2300 Roslyn Ave. Date signed 6/1/44

Huntington Hall, Md.

MD 17783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17783

Registered No. 1134a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Brightwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Brightwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EUGENE FREDERICK

3 (b) If veteran, name war: World

3 (c) Social Security Account No.: --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara A. Frederick

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1/3/1891

8. AGE: Years	Months	Days	If less than one day
53	4	29	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Lawyer

11. Industry or business: Self

FATHER
12. Name: George H. Frederick
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Maggie Trent
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Clara A. Frederick
(b) Address: 3208 Brightwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JUN 3 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at 2:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to June 2, 1944 and that I last saw h alive on 19

Immediate cause of death: Acute Dilatation of Heart - Duration: 18 hrs

Due to: Coronary Thrombosis 6 days

Due to:

Other Conditions: Renal Calculi of Left Kidney

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin W. Groob M. D.
Address 2062 Fulton Ave Date signed 6-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 17784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: McKenna Memorial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2043 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LYDIA L. MARSDEN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 215-07-9865

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1869

8. AGE: Years	Months	Days	If less than one day
75	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Dress Maker
11. Industry or business Shoen & Russell

FATHER
12. Name James Marsden
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Davies
15. Birthplace Phila. Pa.

16 (a) Informant Mr. Arthur Earp
(b) Address 2043 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1944 Balto., Md.

19 JUN 3 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to June 1 1944; and that I last saw h[illegible] alive on May 31 1944

Immediate cause of death: Hemaplegia - Rt Side — Duration: 11 days
Due to: Chr. Arteriosclerosis. — Duration: Indefinite
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Nathaniel M Beckwith M. D.
Address 2727 N. Charles Date signed June 2-44

Registrar Washington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B 17785.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. B 17785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2835 Winchester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRA WESLEY SHIPLEY

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-16-1819
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Olive S. Shipley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 9, 1871
8. AGE: Years 73 | Months 4 | Days 23 | If less than one day hr. min.
9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Laundry
11. Industry or business Elite Laundry

FATHER
12. Name William Shipley
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Rebecca Wesley
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Olive Shipley
(b) Address 2835 Winchester Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.,
Location A. A. Co., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.
19 (a) Received by registrar JUN 3 1944 (b) Registrar
VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 2, 1944, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Apr 1944, to 2 June 1944, and that I last saw h[illegible] alive on 1 June 1944.

Immediate cause of death: Metastatic Carcinoma of Liver; acute obstruction of bile passage
Due to
Due to Sarcoma Hemorrhage
Other Conditions

Duration: for 10 apr to June 2.

(Include pregnancy within 3 months of death)
Date of operation 11 Jan 39
Major findings of operation: Fibro-carcinoma - colon.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 2925 N Charles St Date signed June 4 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 17786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

D 17786 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution: KIRKLEIGH VILLA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 FLEETWOOD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANN HESS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JOHN HESS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APR. 20 1863

8. AGE: Years 81 | Months 1 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual Occupation: HOUSE WIFE AT HOME
11. Industry or business

FATHER
12. Name: CASPER FISHER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: CATHERINE NOE
15. Birthplace: GERMANY

16 (a) Informant: MRS. EDGAR LIDARD (DAUGHTER)
(b) Address: 2709 FLEETWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 5/44 (month) (day) (year)
(c) Cemetery or crematory: SACRED HEART CEM.
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly & Zeiler inc.
(b) Address: 403 S. WOLFE ST.

19 (a) (Date received by registrar) JUN 3 - 1944 Huntington Williams, M.D.
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 1944 at 7/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to June 1 1944, and that I last saw h[er] alive on May 31 1944.

Immediate cause of death	Duration
Heart Failure	1 day
Due to Cancer of Liver	1 MO.
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Meeks
Address 5276 Park Heights Date signed June 7 44

G 1778?

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 1778?

CERTIFICATE OF DEATH √160c

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Kernan's Hosp St. Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME William Totten Latane

If U. S. Veteran specify WAR

(a) Residence: No. 4300 Hayward Ave St., 28-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year): Mar 29/1944

7. AGE — Years | Months: 2 | Days: 4 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Balto Md.

FATHER

13. NAME: Lewis M Latane"

14. BIRTHPLACE (city or town) (State or country): Virginia

MOTHER

15. MAIDEN NAME: Annie B Totten

16. BIRTHPLACE (city or town) (State or country): Virginia

17. INFORMANT: Lewis M Latane
(Address) 4300 Hayward Ave

18. BURIAL, CREMATION, OR REMOVAL
Place: Burial Parkwood Cemetery Date: June 3 19[illegible]

19. UNDERTAKER: Ellsworth Maynard
(Address) 3911 Liberty Heights Ave

20. Filed JUN 3 1944 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): June 2, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 16, 1944 to June 2, 1944

I last saw h[illegible] alive on June 2, 1944. Death is said to have occurred on the date stated above, at 1:25 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Dislocation of cervical spine with complete Laceration of cord	Mar 29 1944

Other contributory causes of importance:
None

Was an operation performed? Yes Date of May 26, 1944

For what disease or injury? Dislocation of cervical spine

Name of operation Cervical Laminectomy

What test confirmed diagnosis? Operation Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No. If so, specify

(Signed) Charles J Basile M. D.

(Address) Kernan Hospital, Balto 7, Md.

V8 5

G 17788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 17788 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 N. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mason Brown

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Separated

6 (b) Name of husband or wife: Sadie
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) July 16 1907

8. AGE: Years	Months	Days	If less than one day
36	10	12	hr. min.

9. Birthplace Howard Co Md. (Town, county, and state)
10. Usual Occupation Tractor Operator
11. Industry or business Contracting

FATHER: 12. Name Mason Brown; 13. Birthplace Howard Co. Md.
MOTHER: 14. Maiden Name Alice Green; 15. Birthplace Howard Co, Md.

16 (a) Informant Eva Drake (Sister)
(b) Address 407 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Charles G. Cooperr
(b) Address 512 N. Carrollton Ave

19 (a) [illegible] (b) Thos. Taylor Hickman, M.D.
JUN 3 1944 For Dr. R. L. Embert by Howard F. Hawkins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1944, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1944 to 5/28 1944, and that I last saw h[illegible] alive on 5/28 1944

Immediate cause of death	Duration
Myocarditis	3 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 760 [illegible] Date signed 6/2 1944

G 17789 — BALTIMORE CITY HEALTH DEPARTMENT — G 17789 Registered No.

CERTIFICATE OF DEATH 46E

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Stratford Road.
(c) Hospital or institution: X
(d) Length of stay in hospital or inst. (yrs., mos., or days) X
(e) Length of stay in Baltimore (yrs., mos., or days) X

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Stratford Road (If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country X

3 (a) FULL NAME James Carey

3 (b) If veteran, name war: X
3 (c) Social Security Account No. X

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ or wife: Laura Hanson Carey
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 16, 1865
8. AGE: Years 79 | Months 9 | Days 16 | If less than one day: hr. min.
9. Birthplace: Delaware County, Pennsylvania (Town, county, and state)
10. Usual Occupation: Wholesale Druggist
11. Industry or business:

FATHER
12. Name: Thomas Irwin Carey
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Martha Gray Leiper
15. Birthplace: Delaware County, Pa.

16 (a) Informant: Laura H. Carey
(b) Address: 204 Stratford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: Henry W. Jenkins Sons
(b) Address: McCulloh & Orchard Sts

19 (a) (Date received by registrar) JUN 3 - 1944 Hampton McNeill, Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1944, to June 1 1944, and that I last saw him alive on June 1 1944

Immediate cause of death: Intestnal hemorrhage — Duration: 2 days

Due to: Probably to ulceration carcinoma (primary) intestinal

Due to: Involing liver — 6 mos.

Other Conditions: Epithelioma left eye (31 years)
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harvey G Back M. D.
Address: 100 E. 23rd Date signed: 6-2-44

G 17790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 17790 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Fields St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Fields St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pleb Anna Leitner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eli K. Leitner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1868

8. AGE: Years 76 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace New Freedom Penna. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert Bradford
13. Birthplace ?

MOTHER
14. Maiden Name Lydia Ann Harris
15. Birthplace ?

16 (a) Informant daughter Lydia Ann McQuethan
(b) Address 765 Bay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Edwards & Donovan
(b) Address 3615 Chestnut Ave

19 JUN 3 - 1944 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Coronary thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian F. Richter

Address 513 Chatsworth Ave. Date signed 6/7/44 M. D.

G 17791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17791 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S.Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S.Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Luckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John W.Luckhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.18-1891

8. AGE: Years	Months	Days	If less than one day
52	7	14 17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Charles Kartivich
13. Birthplace Austria
14. Maiden Name Catherine Renner
15. Birthplace Austria

16 (a) Informant John W.Luckhardt
(b) Address 620 S.Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baker Rd.

18 (a) Funeral director John L. Mellor
(b) Address 253 Jefferson St

19 (a) JUN 3 1944 Registrar Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 6/1 1944, and that I last saw h-r alive on 6/1 1944.

Immediate cause of death Chronic Myocarditis — Duration

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Tankey
Address 441 S. Kelwood Ave Date signed 6/2/44 M.D.

G 17732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G 17732

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hosp. 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Buchanan Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John A. Cox

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 717-07-8787

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-85

8. AGE: Years 58 | Months 11 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Richmond Virginia (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Penn. R. R.

FATHER
12. Name John H. Cox
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Sophia R. Carey
15. Birthplace Richmond Va.

16 (a) Informant Mrs. Florence E. Clarke
(b) Address 4405 Buchanan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Marys Hampden
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 Filed JUN 2 - 1944 (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1944, at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944 to 6/2 1944 and that I last saw h--- alive on 6/1 1944.

Immediate cause of death Carcinoma of Pancreas — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operation None (5/27/44)
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Leahy M. D.
Address Fr. Sq. Hosp. Date signed 6/2/44

G 17793 X G 17793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 West Midland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** [Baby Girl] Alt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Kenneth Alt
13. Birthplace New York

MOTHER
14. Maiden Name Edith Simons
15. Birthplace West Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JUN 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 3 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1 1944 at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1944 to 6-1-1944 and that I last saw her alive on 6-1 1944.

Immediate cause of death	Duration
Anoxia	5 hrs
Due to Congenital Cardiac Abnormality	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Abnormal congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harrison Letta M. D.
Address Church Home & Hospital Date signed 6-2-44

0985

C 17794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C 17794

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Ya correct age is especially important. Physicians: please write t the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 19½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-31-44

8. AGE: Years	Months	Days	If less than one day
			13½ hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charlie Mitchell
13. Birthplace Raleigh N. C.

MOTHER
14. Maiden Name Josephine Kelley
15. Birthplace Camden S. C.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 2 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUN 3 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31 1944, at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 1944, to 5-31 1944, and that I last saw him alive on 5-30 1944.

Immediate cause of death: Premature Birth — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles V. Wardell M. D.
Address 2 E. Preston Date signed 6/1/44

0984

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937D

G 17795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3417 Brendan Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

6-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Charlott Kentner

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband or wife Casper Kentner
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July, 7, 1870

8. AGE: Years	Months	Days	If less than one day
73	10	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name Charles Fritsch
13. Birthplace Germany
14. Maiden Name Elizabeth Benning
15. Birthplace Germany

16 (a) Informant Mrs. Anna Stacey Kentner
(b) Address 3417 Brendan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 JUN 3 - 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 3 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 44 1944, to 5/31 1944 and that I last saw h[er] alive on 5/31 44 1944.

Immediate cause of death Pneumonia Acute — Duration 24 hrs
Due to Cardio Vascular Disease — 3 yrs
Due to Hypostatic arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Sander M.D.
Address 100 n mellowes Date signed 6/1/44

G 17796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G 17796

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Silver Hill Ave.
(c) Hospital or institution:
28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Silver Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maud Vernon Gerhard

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married Gerhard

6 (b) Name of husband or wife George Frederick
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1893

8. AGE: Years	Months	Days	If less than one day
51	2	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Roberts
13. Birthplace Maryland

MOTHER
14. Maiden Name Marcelena Berry
15. Birthplace Not Known

16 (a) Informant Mr. Geo. F. Gerhard
(b) Address 2802 Silver Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto.

18 (a) Funeral director Henry Sadder & Sons. Inc.
(b) Address North Ave. & Broadway

19 JUN 3 - 1944 Rec'd by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to June 1 1944, and that I last saw h-- alive on May 31 1944.

Immediate cause of death	Duration
Acute Myocarditis	
Due to Endocarditis	
Due to Hypertension	
Other Conditions Diphtheria	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Walter Hoover
Address 4012 Edmondson Date signed 6/1/44

G 17797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17797 Registered No. 4612

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Use correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie Rebecca Fine

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Francis Fine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22-1879

8. AGE: Years 64 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Henry Hobson
13. Birthplace Maryland

MOTHER
14. Maiden Name Agnes Ann Green
15. Birthplace Maryland

16 (a) Informant Mrs. Thaddeus V. Coe
(b) Address 3519 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3-1944 (month) (day) (year)
(c) Cemetery or Crematory Lorraine
Location Baltimore Co. Md.

18 (a) Funeral director Duray Funeral Home
(b) Address 3944 Falls Road

19 (a) JUN 3 1944 (Date rec'd by registrar) (b) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31- 1944, at 10-05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to May 1944, and that I last saw her alive on May 31 1944.

Immediate cause of death Pulmonary Edema — Duration about 2 days

Due to Metastatic Carcinoma from stomach — Duration about 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lemuel V. T. Marlene M. D.
Address 900 W. 37th St Date signed 6-2-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30 #67486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 12798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 W. Hill St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Arthur Jackson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Katie Jackson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 4, 1880
8. AGE: Years 64 Months -3- Days 23 If less than one day hr. min.
9. Birthplace Iowa (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Gus Jackson
13. Birthplace Alabama
MOTHER 14. Maiden Name Mattie Alexander
15. Birthplace Alabama
16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Location Baltimore City.
18 (a) Funeral director Joseph A. Smith
(b) Address 4019 Mount Street
19 (a) JUN 3 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1944, at 10:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1944, to 5-27 1944 and that I last saw him alive on 5-27 1944.

Immediate cause of death: Pulmonary tuber-culosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul McBee M. D.
Address B.C.H. Date signed 6-2-44

G 17799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G 17799 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital 98
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 East 25th street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Bangert Mr Harry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Mrs Mary Bangert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 - 1896

8. AGE: Years	Months	Days	If less than one day
47	11	14/16	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Store keeper
11. Industry or business

FATHER
12. Name William N Bangert
13. Birthplace Germany

MOTHER
14. Maiden Name Anne Schneider
15. Birthplace Baltimore Md

16 (a) Informant Wife
(b) Address 635 East 25th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director C. J. Fleming & Son
(b) Address 1938 E. Lafayette Ave

19 (a) JUN 3 - 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to May 31 1944, and that I last saw him alive on May 31 1944.

Immediate cause of death Acute cardiac failure (circulatory collapse)
Due to Coronary occlusion
Due to
Other Conditions Cholelithiasis.
(Include pregnancy within 3 months of death)
Date of operation May 31, 1944
Major findings of operation Cholelithiasis.
of autopsy Coronary occlusion

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Talbot Jr M. D.
Address Church Home & Hosp. Date signed 6/1/44.

G 17800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17800 ✓ §3a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5021 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Libourne P. Irvine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1891

8. AGE: Years 52 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md W. Va (Town, county, and state)

10. Usual Occupation Clerk Sanders

11. Industry or business Bethlehem Steel Corp

FATHER 12. Name Rev. Howard Irvine

FATHER 13. Birthplace Balto. Md Hunterstown

MOTHER 14. Maiden Name Unknown McPhills

MOTHER 15. Birthplace Va Unknown

16 (a) Informant Margaret Irvine

(b) Address 336 S. Wayne ave Wanneljona Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)

(c) Cemetery or crematory Greenhill Cem

Location Churchville Md

18 (a) Funeral director E. Wallis Lamoreaux

(b) Address 1005 W Baltimore St

19 (a) (b) Huntingtown Md.

Filed JUN 3 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31/1944, at 1:30 A M

21. I certify that I took charge of the remains described above, hold an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 5/31/44

G 17801 V G 17801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert Sts.

(c) Hospital or institution: Union Memorial Hosp. 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Pikesville 2

(If outside city or town limits, write RURAL and give town)

(d) Street No. 106 Brightside Ave.

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Vernon Jennings Creighton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1896

8. AGE: Years	Months	Days	If less than one day
48	2	7	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER

12. Name Wm. H. Creighton (D)

13. Birthplace Maryland

MOTHER

14. Maiden Name Lenora Travers (D)

15. Birthplace Maryland

16 (a) Informant Mrs. George Eckenrode

(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/44 (month) (day) (year)

(c) Cemetery or crematory Alms Chapel

Location Pikesville, Md.

18 (a) Funeral director Frank A. Ward

(b) Address Pikesville Md

JUN 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1944 at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 1944, to 5-31 1944, and that I last saw him alive on 5-31 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Carcinomatosis (Abdominal)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.

Address U.M.H. Date signed 5-31-44

C 17802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C 17802

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct. Be sure to write the age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Mc Daniels

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Flora.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1901

8. AGE: Years 42 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Prince George Co., Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Mc Daniels
13. Birthplace Prince George Co., Va.

MOTHER
14. Maiden Name Eliza Brown
15. Birthplace Prince George Co., Va.

16 (a) Informant Ellen Slaton
(b) Address 1018 N. Mount St.

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof 6-3-44 (month) (day) (year)

(c) Cemetery or crematory
Location Glairemont Va.

18 (a) Funeral director Mrs Lee H Holland
(b) Address 1631 Druid Hill Ave

19 (a) JUN 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture 1 5th & 6th cervical vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-28-44 a. 3:30 P. M. 3/1
(b) Where did injury occur? 1507 Eastern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes.
(d) Means of injury Fell off ladder, 15 ft. Fracture.

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed June 5 1944

VS 151

17803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G 17803

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 S. Fremont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 S. Fremont St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth L. Selby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Catherine Selby | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 - 1870

8. AGE: Years 74 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Wm H. Selby
13. Birthplace Maryland

MOTHER — 14. Maiden Name Mary Brown
15. Birthplace Maryland

16 (a) Informant Mary Selby
(b) Address 422 S. Fremont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. S. Shipley Son
(b) Address 300 Eutaw Place

19 (a) Embalmer (b) Huntington Williams M.D. Registered

JUN 3 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1944, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 19 44 to 6/2 19 44
and that I last saw h alive on 6/2 19 44

Immediate cause of death: Bronchopneumonia — Duration: 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2032 Wilkens Ave Date signed 6/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 17802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Lucy Eyster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/24/1871

8. AGE: Years 73 | Months 3 | Days 9 | If less than one day — hr. — min.

9. Birthplace Adams County, Pennsylvania
(Town, county and state)

10. Usual Occupation Nursing Deaconess

11. Industry or business

FATHER 12. Name Peter Eyster
13. Birthplace York County Pa

MOTHER 14. Maiden Name Elizabeth Forbe
15. Birthplace York County Pa

16 (a) Informant Lutheran Deaconess Home
(b) Address 2500 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Pennsylvania

18 (a) Funeral director F. B. Wippert & Son
(b) Address 4344 Eastern Ave

JUN 3 - 1944 (Date rec'd by registrar) (b) Registrar Hampton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 — 1944 at 12 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to June 2 1944 and that I last saw her alive on June 2 1944.

Immediate cause of death Uremia — Duration

Due to Ileus

Due to

Other Conditions Arteriosclerotic CVD
Cerebral damage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Capt. Carl Myers MC
Address 1st Gen. Hosp. Date signed 6/2/44

17805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 937

Registered No. C 17805

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Greene
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Washington D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Penn St. N.E. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Catherine Elizabeth Oliveri

3 (b) If veteran, name war ..... 3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Paul F. Oliveri
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 21st 1908

8. AGE: Years 35 | Months 8 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Detroit, Va. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business .....

FATHER
12. Name Santanna Clem
13. Birthplace Shenandoah County Va

MOTHER
14. Maiden Name Sarah Jane Walters
15. Birthplace Shenandoah County, Va

16 (a) Informant Husband
(b) Address Same as decedent.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 3-44 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location Washington D.C.

18 (a) Funeral director W. W. Chambers Co.
(b) Address 1217 St Paul Street

19 (a) ..... (b) Washington D.C. William M.D.

JUN 3 - 1944 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 3 1944, and that I last saw he/she alive on June 3rd 1944.

Immediate cause of death	Duration
Pulmonary Congestion	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions Tuberculosis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: No
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature J. Gentleman M.D.
Address University Hosp. Date signed 6/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write correct age is especially important.

17806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. 17806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5502 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 5502 Arabia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Frederick Haile Foard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth Mann
6 (c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): March 11, 1889
8. AGE: Years 55 | Months 2 | Days 20 | If less than one day: hr. min.
9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual Occupation: Engineer
11. Industry or business

FATHER
12. Name: Albert Foard
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Laura Cairnes
15. Birthplace: Balto. Co. Md.

16 (a) Informant: Mrs. Ruth M. Foard
(b) Address: 5502 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3, 1944 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemy.
Location: Taylor Ave. Parkville, Md.

18 (a) Funeral director: John O. Mitchell & Sons
(b) Address: 1900 Eutaw Place

19 JUN 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943, to June 1 1944 and that I last saw h. im alive on June 1 1944.

Immediate cause of death: Uremia — Duration: 6 days

Due to: Chronic nephritis — Duration: Years.

Due to: Contracted kidney — Duration: 8 Years.

Other Conditions: Hypertension — Duration: 8 Years.

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Henry L. Hermann M. D.
Address 20 E. Preston St. Date signed 6/2/44

Dr. Hermann

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1641 Carswell st
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Carswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallye R. Bush

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-01-1443

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1. 1875

8. AGE: Years	Months	Days	If less than one day
69	4	1	hr. min.

9. Birthplace Hillsboro Md (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Mayers Dept Store

FATHER
12. Name James A. Bush
13. Birthplace Caroline Co. Md.

MOTHER
14. Maiden Name Eliza B. Hindman
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Clara Bowman
(b) Address 1641 Carswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Road

18 (a) Funeral director Elmer W. Conkling & Son
(b) Address 924 E. Eager St.

19 (a) [illegible] (b) [illegible]

JUN 4 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19XX to 6/2 19XX, and that I last saw h[illegible] alive on 6/2 19XX.

Immediate cause of death. Chronic Myocarditis — Duration

Due to — Duration

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tyson Holley M. D.
Address 5703 Harford Rd Date signed 6/3/44

G 17809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 17808 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Use additional sheet if necessary. Do not abbreviate. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 E. 30th St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Linda Lee Edna Gisiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1943

8. AGE: Years	Months	Days	If less than one day
	9	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred. Wm. Gisiner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. Stull
15. Birthplace Pa.

16 (a) Informant Mrs. Frederick W. Gisiner
(b) Address 705 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3rd (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Ave.

18 (a) Funeral director Elmer W. Conflisenon
(b) Address 924 E. Eager St.

19 6 - 1944 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1944, at 10 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31 1944, to 6/1 1944, and that I last saw her alive on 6/1 1944

Immediate cause of death: Bilateral otitis media, + Rt. Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Leahy M.D.
Address Fr. Sq. Hosp. Date signed 6/1/44

VS 2

G 17809 ✓ G 17809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered (if none, so state). Do not abbreviate. Give full name of street and number. Also write the causes of death clearly and legibly. Where death occurred in a hospital or institution, do not report the ward or room number. Please state whether single, married, widowed, or divorced. Also write the maiden name of every married woman. Be sure that the age is correctly stated. Physicians: please write your orders plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 951 N. Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 951 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Mirschberger

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife 9
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1879

8. AGE: Years	Months	Days	If less than one day
64	11	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laundry Business
11. Industry or business

FATHER
12. Name John K. Mirschberger
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine E Holtz
15. Birthplace Germany

16 (a) Informant John F. Mirschberger
(b) Address 951 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Elmer J. Conklin Son
(b) Address 92 E. Eager St.

19 JUN 4 - 1944 (Date rec'd by local reg.) (b) Frank Lyon Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1944, at 11 20 A M

21. I certify that I took charge of the remains described above, held an Inquiry - Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. Disease
& Coronary Occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester F. Jablonski M.D. Medical Examiner.
Date signed 6/3/44

VS 151

G 17810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C Registered No. G 17810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude Hilliard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry A. Hilliard
13. Birthplace N.C

MOTHER
14. Maiden Name Wakefield
15. Birthplace

16 (a) Informant J. H. Wilkinson Funeral Home
(b) Address Concord. N.C.

17 (a) Removal (b) Date thereof 6/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Concord.
Location N.C.

18 (a) Funeral director Wm Cook Jnr
(b) Address 1215 E Baltimore St.

19 (a) 1944 (b) [illegible] M.D.
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3-1944, at 4:45 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Fractured ribs, emphysema
Fractured humerus.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 11-1
(a) Date of injury 5/19/44 at 11:55 P M.
(b) Where did injury occur? Mt. Royal Ave, nr. Guilford Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 6/3/44

C 17817 ✓ C 17811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Louis H Lenhart

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Gillis
6 (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) Dec 18 1875

8. AGE: Years	Months	Days	If less than one day
68 67	5	13	..... hr. ..... min.

9. Birthplace Frederick Co Md (Town, county, and state)
10. Usual Occupation Car Builder
11. Industry or business Railroad

FATHER
12. Name Lenhart
13. Birthplace Frederick Co

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Margaret Lenhart
(b) Address 2432 Edmondson Ave
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave
18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Gilmor
19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944 at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. Wollenweber M.D. (Medical Examiner.)
Date signed June 2, 1944.

C 17812 C 17812 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Uver Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson Barrio

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Amanda
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 14 1891

8. AGE: Years	Months	Days	If less than one day
53	4	19	hr. 1885 min.

9. Birthplace Kentucky
(Town, county, and state)
10. Usual Occupation Pipefitter
11. Industry or business Shipyard

FATHER
12. Name Geo Barrio
13. Birthplace Kentucky

MOTHER
14. Maiden Name Judy Monrad
15. Birthplace Kentucky

16 (a) Informant Mrs Amanda Barrio
(b) Address 1300 Uver Court

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Morehead Cem
Location Moorhead Kentucky

18 (a) Funeral director Thos F Kenny
(b) Address Hollins & Gilmor

19 (a) Date rec'd JUN 4 1944 (b) [illegible] Registrar

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3-1944 at 2:40 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Multiple fractured ribs, Multiple bruises & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/3/44 at 1.40 A M. 25-2
(b) Where did injury occur? Hanover St. Bridge, Sparr
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 6/3/44

C 17813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 12

C 17813

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 124 N Ellwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 124 N Ellwood Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Flaherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single, married,~~ widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1863

8. AGE: Years 80 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business None

MOTHER / FATHER

12. Name

13. Birthplace

14. Maiden Name Sarah Welch

15. Birthplace Ireland

16 (a) Informant Sarah Flaherty

(b) Address 124 N Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/44 (month, day, year)

(c) Cemetery or crematory New Cath. Cem. Location Old Frederick Rd

18 (a) Funeral director John G Horan

(b) Address 3000 E Baltimore St

JUN 4 1944 (Date Received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1934 to June 3 1944 and that I last saw him alive on June 2 1944

Immediate cause of death Heart Failure — Duration 1 day

Due to Carcinoma prostate + Skin

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W S Keagy

Address Hosp E Baltimore Date signed 6/7/44 D.

G 17811 ✓ G 17812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 35 N Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 N Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Guemple

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4-1870

8. AGE: Years	Months	Days	If less than one day
73 74	11	28	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Ellen Mathieu
(b) Address 35 N Ellwood Ave

17 (a) Burial (b) Date thereof 6/6/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location Old Frederick Rd

18 (a) Funeral director John A. Hogan
(b) Address 3010 E. Baltimore

JUN 4 1944

19 (a) (b)
(Date rec'd by registrar) Thurlington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944 at 9.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 25 1944, to JUNE 2 1944, and that I last saw her alive on JUNE 2 1944.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	8 DAYS
Due to ARTERIOSCLEROSIS	6 YEARS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James T. Kavanagh M.D.
M. D.
Address 3628 McElderry St Date signed 6-3-44

G 17815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17815 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Aye
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott Polan

3 (b). If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1926

8. AGE: Years	Months	Days	If less than one day
18	1	22 21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Samuel Polan
13. Birthplace Russia

MOTHER
14. Maiden Name Lillian Gordon
15. Birthplace Baltimore, Md

16 (a) Informant Samuel Polan
(b) Address 1513 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUN 4 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1944, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 6/3 1944, and that I last saw him alive on 6/3 1944.

Immediate cause of death	Duration
Cardiac respiratory failure	
Due to Pulmonary edema	
Due to Rheum. Card Val Disease	
Other Conditions Widespread Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Widespread Disease, Pulm. Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Polan

Address Sinai Hosp. Date signed 6/3/44 M.D.

C 17816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C 17816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 N Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 N Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. Goldstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Isaac Goldstein
13. Birthplace Russia

MOTHER
14. Maiden Name Mary ?
15. Birthplace Russia

16 (a) Informant Mr Meyer Caplan
(b) Address 3512 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave
(c) JUN 4 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1944, at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to 6/3 1944, and that I last saw him alive on 6/3 1944.

Immediate cause of death: Coronary Occlusion — Duration: 12 hrs

Due to: 1

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. Levy, Samson

Address 2128 W. North Ave Date signed 6/3/44

G 17817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944 G 17817

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3910 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 69
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Caplan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Cabinet Maker

FATHER
12. Name Harry Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name Reva ?
15. Birthplace Russia

16 (a) Informant Loius Caplan
(b) Address 3910 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Anshe Emunah Location Cemet. Washington Rd.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Date received (Registrar) JUN 4 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 19 to 6/2 1944 and that I last saw h[illegible] alive on 6/2 1944

Immediate cause of death	Duration
Acute Bronchopneumonia	
Due to Chronic Arteriosclerosis	
Due to	
Other Conditions Parkinson's Disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Saint Date signed 6/3/44

Dr Hornstein

C 1818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C 1818

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Any supplementary information required to complete the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 White Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 White Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Charles Lydick (née Richert)

3 (b) If veteran, name war

3 (c) Social Security Account No. 351-07-4401

4. Sex: M

5. Color or race: Wh

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Hawthorne (nee Toahunter) Dunn

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov. 17th 1895

8. AGE: Years 48 | Months 6 | Days 16 15 | If less than one day hr. min.

9. Birthplace Williamsport, Penna.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Bus Transportation Co.

FATHER
12. Name John Richert
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Hanna Lydick
15. Birthplace Penna.

16 (a) Informant Mrs. J. C. Lydick
(b) Address 4614 White Ave.

17 (a) Burial (b) Date thereof 6 5 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bakewood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

JUN 4 1944 (b) Baltimore, Md.
(Date received) (Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2- 1944, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from at death 19..., to 19..., and that I last saw him alive on 19...

Immediate cause of death: Coronary Disease (acute Angina). — Duration 3½ hrs.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 6-2-44

G 17819 G 17819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct and complete. Physicians: please write age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Walbash Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3519 Walbash Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Harry Cushnew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Evelyn Lee Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Isaac Cushnew
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam —
15. Birthplace Russia

16 (a) Informant Mrs. Evelyn Cushnew
(b) Address 3519 Walbash Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-44 (month) (day) (year)
(c) Cemetery or crematory Pinedale
Location

18 (a) Funeral director Jack Reiss Inc
(b) Address 1439 E. Balto St

19 (Signature of person acting as funeral director) Herrington-Williams, Inc.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at 8.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944 to June 3 1944 and that I last saw him alive on June — 1944.

Immediate cause of death: Acute Cardiac Failure
& Coronary Thrombosis — Duration 5 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohman M.D.
Address 1921 W North Ave Date signed 6/5/44

G 17820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G 17820 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 W. Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Simon Gandel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sarah -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Net

11. Industry or business

FATHER
12. Name -
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Leon Sadler
(b) Address 3314 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-44 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem
Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto. St

19 (a) JUN 4 1944 (Date received by Registrar) (b) Washington Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944, to June 4 1944, and that I last saw him alive on June 4 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertensive cardio vascular disease

Due to:

Other Conditions: Carcinoma of the larynx
(Include pregnancy within 3 months of death)

Date of operation May 25, 1944

Major findings of operation: Carcinoma of larynx

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Sadler M.D.

Address Sinai Hosp Date signed 6/7/44

C 17821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1382

Registered No. C 17821

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Greene
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 White Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Abraham Sauber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Sauber

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1894

8. AGE: Years	Months	Days	If less than one day
49	5	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER
12. Name Adolph Sauber
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Sauber
15. Birthplace Russia

16 (a) Informant Wife
(b) Address Same as deceased

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-44 (month) (day) (year)
(c) Cemetery or crematory Washington Relig
Location Wash. Blvd

18 (a) Funeral director Jos. Levi Sons
(b) Address 1439 E. Baltimore St

JUN 4 - 1944 (b) Huntington Williams Mfr
(Date rec'd by Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1944, to June 2 1944, and that I last saw him alive on June 2 1944.

Immediate cause of death	Duration
Hypertensive Cardio Vascular disease	
Due to	
Due to	
Other Conditions Tuberculosis	over

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Guthman / Dr. Carey M. D.
Address University Hosp. Date signed June 2 1944

C 17822 C 17822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 Warner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Warner St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Kell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie Kell
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 12/25/72

8. AGE: Years 71 | Months 5 | Days 6 | If less than one day: hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Basil Kell
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Mary Howard
15. Birthplace Calvert Co.

16 (a) Informant Sophie Kell
(b) Address 932 Warner St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/4/44 (month) (day) (year)
(c) Cemetery or crematory Island Creek Cem
Location Calvert Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1050 Montgomery St
(c) Huntington Williams, Mgr.

JUN 4 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31/1944 at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3/1944 to 5/31/1944 and that I last saw h alive on 5/30/1944

Immediate cause of death Myocarditis — Duration
Due to Arteriosclerosis & gangrene
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. A. Harriet M. D.
Address 608 N. Carrollton Ave Date signed 6/3/44

C 17823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

C 17823

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Koch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or Race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 1860

8. AGE: Years	Months	Days	If less than one day
84	4	4	hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Heinrich Koch

13. Birthplace Germany

14. Maiden Name Edna B.

15. Birthplace Germany

16 (a) Informant Mary Koch

(b) Address 2209 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1944 (mo.) (day) (yr.)

(c) Cemetery or crematory Greenmount Cemetery

Location Greenmount Ave

18 (a) Funeral director J. Ahrens & Co

(b) Address 943 Reisterstown Rd

19 (a) (Date received by Registrar) (b) Registrar

JUN 1 1944

Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1944 to June 3 1944 and that I last saw h[illegible] alive on June 3 1944

Immediate cause of death Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

Means of injury

23. Signature J. Elw Talbot M. D.

Address 2763 St Paul St Date signed 6/7/44

G 17824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.93E

G 17824 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4205 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4205 Ridgewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lily H. Feulner

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-2870

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 28/1884

8. AGE: Years 60 | Months 4 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business A.S. Mentzel Paper Co

FATHER
12. Name Frank Feulner
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara A. Feulner
15. Birthplace Baltimore Md

16 (a) Informant Ada M. Feulner
(b) Address 4205 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5/1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Harry A. Amacost
Address 4 Ridgewood Ave

JUN 4 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 5 1944 and that I last saw h[illegible] alive on June 5 1944.

Immediate cause of death	Duration
Coronary Occlusion	2 hours
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Samuel M. D.
Address 4509 Eastern Ave Date signed June 4

G 17825 (Over)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56a

G 17825

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Rd
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4724 Dunkirk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille J Shanks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Ashby D Shanks

6 (b) Name of husband or wife

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) July 11 1900

8. AGE: Years	Months	Days	If less than one day
43	10	22	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business at home

FATHER
12. Name Wesley Shifflette
13. Birthplace Virginia

MOTHER
14. Maiden Name Ella Connolly
15. Birthplace Virginia

16 (a) Informant Ashby D. Shanks
(b) Address 4724 Dunkirk Ave

17 (a) Burial (b) Date thereof June 5 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Ellsworth Thompson
(b) Address 3911 Liberty Heights Ave

19 (a) (b) Registrar
(Date received by Registrar)

JUN 4 1944

Huntington Hitchcock, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2/ 19 44 at 740 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 19 44 to 6/2 19 44 and that I last saw her alive on 6/2 19 44.

Immediate cause of death Pericarditis — Duration

Due to Ruptured

Due to Abscess of Lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature 9th Byrne M. D.

Address Catonsville Md Date signed 6/2/44

St Agnes Hospital

S 180

G 17826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G 17826 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Carey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 15 - 1893

8. AGE: Years 51 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Mt. Winans - Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Milton Carey
13. Birthplace Mt. Winans - Md

MOTHER
14. Maiden Name Margaret Powell
15. Birthplace Montgomery Co. Md

16 (a) Informant Mrs. Sedonia Burns
(b) Address 28 - N. Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 4 - 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans - Md.

18 (a) Funeral director Mrs. Katie E. Williams
(b) Address 322 N. Schroeder St.

19 (a) JUN 4 1944 (Date received by Registrar) (b) Thos. Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944 to 5/30 1944, and that I last saw him alive on 5/30 1944.

Immediate cause of death: Hemmorrhage — Duration: 4 days

Due to: Gastric ulcers

Due to:

Other Conditions: Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not taken

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C A Kemper M. D.
Address Date signed

G 1782?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 1782?
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2571 W. Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 72

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2571 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Thomas Watts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary R. Watts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1872

8. AGE: Years 72 | Months 1 | Days 5 4 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business National Store Fixtures Co

FATHER
12. Name Samuel Watts
13. Birthplace Maryland

MOTHER
14. Maiden Name Cook
15. Birthplace Maryland

16 (a) Informant Samuel W. Watts
(b) Address 1130 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5-1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George L. Liguori
(b) Address 7101 Frederick ave.

19 (a) 6/4/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to June 2 1944 and that I last saw him alive on June 1 1944

Immediate cause of death Arteriosclerotic myocarditis — Duration ?
Due to Generalized arteriosclerosis — ?
Due to
Other Conditions Hypertensions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris Schreiber M. D.
Address 5-4 S. Fulton Ave Date signed 6-3-44

VS 150

C 17823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C 17823 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2047 Hollins Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 Hollins Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Virginia M. Winkler

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: John L. Winkler
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 8, 1882

8. AGE: Years	Months	Days	If less than one day
54	10	26	hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles A. Gietzhall
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: ?
15. Birthplace: Pennsylvania

16 (a) Informant: John Winkler
(b) Address: 2047 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - - 44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Holly Springs
Location: Carlisle, Pennsylvania

18 (a) Funeral director: Hugo H. Schmit
(b) Address: 2101 Frederick Avenue

19 (a) 6/4/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1944, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 19 44 to 6/3 19 44 and that I last saw h[illegible] alive on 6/3 19 44.

Immediate cause of death	Duration
arteriosclerotic cardio vascular disease	1 yr
Due to	
Due to arteriosclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 30 Wilkens Ave. Date signed 6/3/44

G 17829 G 17829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1610

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 E. Belmont (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Herzberger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Infant
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 31, 1944

8. AGE: Years — Months — Days 1 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Pvt. Melvin L. Herzberger
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Eva L. Gurry
15. Birthplace Baltimore Md

16 (a) Informant Charles L. Herzberger
(b) Address 601-5 E. Belmont Ave. (30)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Md

18 (a) Funeral director C. Howard Evans
(b) Address 4000 Charles St. (30)

19 (a) June 4 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944, to June 2 1944, and that I last saw him alive on June 2 1944.

Immediate cause of death Atelectasis — Duration —

Due to — —

Due to — —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Paul G. Lukats
Address 1213 Light St. Date signed 6/2/44 (M.D.)

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1B

C 17830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 E Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Morrison Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Rhodes (Rhoades)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John O. Rhoades
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 24 1914

8. AGE: Years 29 | Months 11 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kazimer Jonusha
13. Birthplace Europe

MOTHER
14. Maiden Name Mary Spanelunas
15. Birthplace Europe

16 (a) Informant John O. Rhoades
(b) Address 4103 Morrison Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. G. O. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) JUN 4 - 1944 (Date rec'd by registrar) (b) Huntington Mills, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 1 1944, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 - 29 1944, to 6 1 1944, and that I last saw h[illegible] alive on 6 - 1 1944

Immediate cause of death: Shock — Duration: 11yrs

Due to: Pneumonectomy - right — Duration: Positive Sputum

Due to:

Other Conditions: Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation 6 - 1 - 44

Major findings of operation: Tuberculosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanowicz

Address St. Joseph's Hosp. Date signed 6-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 17831

131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Sinai Hebrew Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4519 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances NEMEC

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anton Nemec

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1874

8. AGE: Years 69 | Months 7 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Lener
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Rose Petrauka
(b) Address 4519 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto. Md.

18 (a) Funeral director Frank Leach Son
(b) Address 900 W. Chester St. 5,

JUN 5 - 1944 Dep't rec'd [illegible] Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 19 44, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 19 44 to 6/1 19 44, and that I last saw h[illegible] alive on 6/1 19 44.

Immediate cause of death	Duration
Myocarditis C-V. disease.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Luketo

Address 1213 Light St. Date signed 6/1/44 (M D)

G 17833 ✓ G 17833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Juanita Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1900

8. AGE: Years 44 | Months - | Days 27 | If less than one day hr. min. 44

9. Birthplace Spartansburg S C (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business

FATHER 12. Name Thomas Smith

13. Birthplace S C

MOTHER 14. Maiden Name Ida Austin

15. Birthplace S C

16 (a) Informant Mrs Juanita Smith wife

(b) Address 607 Pennsylvania ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8th 44 (month) (day) (year)

(c) Cemetery or crematory

Location Winston Salem N. C

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Brantley

19 (a) (Date received) Huntington Williams Registrar

JUN 5 - 1944

V 5-51

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944 at 7:20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Ruptured Aortic Aneurysm

Due to

Other Conditions Syphilis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mullen M.D. (Medical Examiner.)

Date signed 6-3-44

17833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 17833

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakeland & Rayner
(c) Hospital or institution:
West Baltimore General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 E. North ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Elizabeth Pelts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1944

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leonard Pelts
13. Birthplace Ohio

MOTHER
14. Maiden Name Essie Walker
15. Birthplace Ohio

16 (a) Informant Mary Pelts
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 5 1944 (Date rec'd by registrar) (Acting for Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3-44 19 . at 12.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944, to June 3 1944, and that I last saw her alive on June 3 1944.

Immediate cause of death Premature birth

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hos. Date signed 6-5-44

VS 150

0986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 17834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3125 Belmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mc. Darity

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Bernard Jr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1875

8. AGE: Years	Months	Days	If less than one day
69	3	8	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John O'Brien
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Murphy
15. Birthplace Canada

16 (a) Informant Hosp. record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1944 (month) (day) (year)
(c) Cemetery or crematory Old Cathedral.
Location Frederick Road

18 (a) Funeral director John C. Moran
(b) Address 3000 E. Baltimore St.

JUN 5 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 3 - 1944 at 0 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 5 - 1944 to 6 - 3 1944 and that I last saw her alive on 6 - 1 1944.

Immediate cause of death Cerebral Embolism.

Due to Emphysema

Due to

Other Conditions arteriosclerosis. Hypertension c.V.D.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Murphy M. D.
Address University Hosp Date signed 6-3-44

G 17835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17835 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 S.Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 S.Decker Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C.Kissner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George N.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.22,1853

8. AGE: Years	Months	Days	If less than one day
90	6	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Adam Klehm
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Lola Kissner
(b) Address 1120 S.Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N Broadway

JUN 5 - 1944 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943, to June 1 1944, and that I last saw h alive on June 1 1944.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Terminal Pneumonia	5-31-44
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E.E. Schumann M. D.
Address 842 S Eutaw Date signed 6-2-44

G 17836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G 17836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S.East Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 S.East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Lipp

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Christine Scholl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13,1868

8. AGE: Years	Months	Days	If less than one day
75	11	19	hr. min.

9. Birthplace Hungry
(Town, county, and state)
10. Usual Occupation Butcher Retired
11. Industry or business

FATHER
12. Name not known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Wife
(b) Address 223 S.East Ave.

17 (a) Burial (b) Date thereof 6/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) JUN 5 - 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to 6/1 1944, and that I last saw him alive on 5/31 1944

Immediate cause of death Cerebral Edema
Hypostatic pneumonia
Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold V. Mowen M. D.
Address 333 S. East Ave. Date signed 6/7/44

VS 150

G 17837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a

G 17837

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 815 Hollins Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County .....

(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 815 Hollins Street (If rural give location)

(e) If foreign born, how long in U. S. A.? 30 years

3 (a) FULL NAME WILHELMINE STEFFEN

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or ~~wife~~: Otto Steffen

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16, 1872

8. AGE: Years 71 72 | Months 10 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mr Horst

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Mr Otto Steffen

(b) Address 819 Hollins Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6-6-1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Cemetery

Location Frederick Road.

18 (a) Funeral director Elliot & Leith

(b) Address 1606 N. Chester Street

19 (a) ..... (Date rec'd by registrar) (b) Thursday for Williams

JUN 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1944, to 6/2 1944, and that I last saw h e alive on 6/2 1944

Immediate cause of death

Due to Myocardial failure

Due to .....

Other Conditions Arteriosclerosis Fibrillation

(Include pregnancy within 3 months of death)

Major findings:

Of operations .....

Of autopsy .....

Duration: 4 mnths

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature J. H. MacMurchy M. D.

Address 706 E Chase St Date signed 6/2/44

G 17833 ✓ G 17833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 W. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1903

8. AGE: Years	Months	Days	If less than one day
41	2	18	hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Arthur Ellis
13. Birthplace Wash. D. C.

MOTHER
14. Maiden Name Martha ?
15. Birthplace Va

16 (a) Informant Mrs Martha Garnett
(b) Address 621 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-44 (month) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co., Md.

18 (a) Funeral director Mrs Frances A. Hennessy
(b) Address 543 W. Biddle St.

19 (a) (b)
Registrar

JUN 5 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at 5:15 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenstein M.D.
Medical Examiner.
Date signed June 2, 1944.

G 17839 ✓ G 17830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Brune Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Brune St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA HEINTZMAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1863

8. AGE: Years	Months	Days	If less than one day
81	5	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Green
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cooper
15. Birthplace Md.

16 (a) Informant Mrs Laura Fuller
(b) Address 1036 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 5 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944 19 , at 1A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 19 44 to June 1 19 44, and that I last saw h alive on June 1 19 44

Immediate cause of death	Duration
Carcinoma Vaginae Uteri	?
Due to Uremia	
Due to Prolapsus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 861 Hart Date signed June 4 1944

b 17840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. B 17840

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Edgevale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 St Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Norman Lehman

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-03-8046

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Olive J Newcomer

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Sept 22 1875

8. AGE: Years	Months	Days	If less than one day
68	8	12	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Elect. Engr

11. Industry or business Oil Burners

FATHER
12. Name Samuel Lehman
13. Birthplace Pa

MOTHER
14. Maiden Name Anna C Middlekauf
15. Birthplace Pa.

16 (a) Informant Marguerite N. Lehman
(b) Address 2408 St Paul St City

17 (a) Cremation (b) Date thereof June 6 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Balto Md

18 (a) Funeral director Henry W Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 1 JUN 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1944, at 11 55 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed June 4 1944

G 1784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 1784 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Maple Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Caroline B. Sykora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10th 1873

8. AGE: Years — Months 8 Days 23 If less than one day hr. min.

9. Birthplace Balto, Maryland (Town, county, and state)

10. Usual Occupation Chief

11. Industry or business

FATHER 12. Name William Sykora
13. Birthplace N.Y.

MOTHER 14. Maiden Name Frances Alberti
15. Birthplace N.Y.

16 (a) Informant William Sykora
(b) Address 827 Maple Ave, Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director W. M. Cook Sons
(b) Address 1217 St. Paul St. Balto, Md.

19 (a) JUN 5 - 1944 (Date received by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fontaine M.D. Medical Examiner.
Date signed June 4 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17812 V G 17812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 Mc Henry st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Mc Henry st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie B. Mullican

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 31st 1892

8. AGE: Years	Months	Days	If less than one day
52	4	1	hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation Clerical Work

11. Industry or business

FATHER
12. Name Ernest N. Mullican
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Alice Creager
15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs Goldie Shaff
(b) Address 721 Mc Henry St

17 (a) Burial (b) Date thereof 6/6/44
(Burial, ~~cremation~~ or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Mt. Olivet
Location Frederick Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) JUN 5 - 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1944, at 11 30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan'y 1944 to 6/2 1944, and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma of Breast	10 yrs
Metastasis to Spine	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Parker M. D.
Address 2145 W Balto St Date signed

1743 BALTIMORE CITY HEALTH DEPARTMENT 937 G 17043
Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 Church ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Church St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lukus Matusevich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation Black Smith.

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace Lith

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace Lith

16 (a) Informant Mrs G. Gorgatas

(b) Address 4313 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jun 6-44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location

18 (a) Funeral director Joseph Kasmatos Jr.

(b) Address 602 Washington Blvd

19 (a) (Registrar) (b) Huntington Ave Baltimore Md.

JUN 5 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Paul Leo Gorgatas M.D.
Medical Examiner.
Date signed June 5 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

317098

G 17844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 17844

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Caroline (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Hart (James William Hart)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna Clancy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-80

8. AGE: Years 64 | Months 1 | Days 19 | If less than one day ########## min.

9. Birthplace Md Baltimore, Md. (Town, county, and state)

10. Usual Occupation Highway Dept.

11. Industry or business

FATHER
12. Name Patrick Hart
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose ## Campbell
15. Birthplace Ireland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 5 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 10 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1944 to June 3 1944 and that I last saw h## alive on June 3 1944

Immediate cause of death: Empyema — Duration: ca 9 d

Due to ruptured esophagus — 11

Due to Ca esophagus — ca Time

Other Conditions Aneurysm Desc. Aorta

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George J. Hayes

Address Date signed 6/5 M. D.

G 17455260 G 17845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95P

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town North East
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar A Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife ANNA

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 10-29-88

8. AGE: Years	Months	Days	If less than one day
55	7	5	hr. min.

9. Birthplace TENN (Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business

FATHER 12. Name John Wesley Smith

13. Birthplace TENN.

MOTHER 14. Maiden Name Elizabeth Howard

15. Birthplace TENN

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 5 1944 (month) (day) (year)

(c) Cemetery or crematory Bristletown

Location Lenox City, Loudon Co TENN

18 (a) Funeral director Joseph A Kiser

(b) Address North Cash Ind

19 (a) (Signature of registrar) (b) Registrar

JUN 5 1944 Huntington Attalaska, Ind.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 4 1944, and that I last saw him alive on June 4 1944

Immediate cause of death Cardiac Failure — Duration 2 hrs

Due to Azotemia

Due to Rheumatic Heart Disease — 34 yrs

Other Conditions Asthma, Hepatomegaly

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laura Dolan

Address Johns Hopkins Date signed M. 6 D. 4/44

G 17816 ✓ G 17816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Gleaves (Gleave)
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Sam Gleaves
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 1, 1896
8. AGE: Years 48 | Months 5 | Days — | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Day
15. Birthplace Maryland

16 (a) Informant Sam Gleaves
(b) Address 905 N. Caroline St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Memorial Park
Location
18 (a) Funeral director Robert L. Green
(b) Address 804 N. Caroline St
19 (a) (b) Huntington, Md.

JUN 5 1944

MEDICAL CERTIFICATION
20. DATE OF DEATH June 1 1944 2:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944 to June 1 1944. and that I last saw h alive on June 1 1944.

Immediate cause of death: Bronchopneumonia — Duration 2 days
Due to: Myocarditis
Due to:
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert A. Aspard M. D.
Address 822 N. Bond St. Date signed 6/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3539 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3539 Old York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. James Harman Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Henrietta C. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15th 1866

8. AGE: Years	Months	Days	If less than one day
77	6	18	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Retired

FATHER
12. Name Harman Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Boyd
15. Birthplace Balto. Md.

16 (a) Informant Miss Henrietta C. Smith
(b) Address 3539 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 | 6 | 44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Jos. Weber & Son
(b) Address 2503 Edmondson Ave

19 (a) (Registrar's signature) (b)

JUN 5 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1944, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to June 3 1944, and that I last saw him alive on June 3 1944.

Immediate cause of death	Duration
Myocarditis	4 days
Due to	
Due to Senility Uremia Dysfunction	3 Mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John N. Evans M. D.
Address 612 N. Eutaw St. Date signed

G 17348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 17348

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: John Hopkins Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days): 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5313 Beaufort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country: —

3 (a) FULL NAME: Edwin C Garrett
3 (b) If veteran, name war: —
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary M Garrett
6 (c) If dead, give age years
7. Birth date of deceased (mo., day, yr.): July 18 - 1875
8. AGE: Years: 68 Months: 10 Days: 15 If less than one day: hr. min.
9. Birthplace: Gloucester N J (Town, county, and state)
10. Usual Occupation: Retired Painter
11. Industry or business: Penn R.R.
FATHER 12. Name: William H Garrett
FATHER 13. Birthplace: unknown
MOTHER 14. Maiden Name: Rebecca J Carson
MOTHER 15. Birthplace: unknown
16 (a) Informant: Mrs Mary M Garrett
16 (b) Address: 5313 Beaufort Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 6 44 (month) (day) (year)
17 (c) Cemetery or crematory: Woodlawn
Location: Baltimore Md
18 (a) Funeral director: Frank H Seitz
18 (b) Address: 2142 W Balto St
19 (a) (b)
Date rec'd by reg. JUN 5 - 1944 Signature for Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 - 3 19YY at 3 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1937 to 6 - 3 19 44 and that I last saw h[illegible]ive on 6 - 3 19 YY.

Immediate cause of death	Duration
Cardiac Decomp.	3 yrs
Arteriosclerosis C V D.	
Due to	
Due to	
Other Conditions: Possibly Ca Prostate	?

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: J Edwards M. D.
Address: 3711 Dolly Rd Date signed 6 - 5 - 44

C 17049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

C 17810

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 S. Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Highland Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Thomas (Baby) Szymborski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	W	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1944

8. AGE: Years	Months	Days	If less than one day
	1	18/19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Szymborske
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lenora Skipped
15. Birthplace Baltimore, Md

16 (a) Informant Lenora Deppel
(b) Address 312 South Highland Ave

17 (a) Burial (b) Date thereof 6/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Martin W. E. Deppel's Son
(b) Address 37 S. Amity St.

19 (a) (Date received by registrar) (b) Registrar

JUN 5 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1944, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Persistent Enlarged Thymus Gland

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Sulkowski M.D.
Medical Examiner.
Date signed 6/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V C 17850

Registered No. 131a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2716 Kildaire Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 Kildaire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Radavich
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Vera
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) May 1870
8. AGE: Years 74 | Months 1 | Days | If less than one day hr. min.
9. Birthplace Lithuania (town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Martin Radavich
13. Birthplace Lithuania

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Lithuania.

16 (a) Informant Vera Radavich
(b) Address 2716 Kildaire Dr.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 6 44 (month) (day) (year)
(c) Cemetery or crematory Wood lawn
Location Wood lawn Md.
18 (a) Funeral director Mart H.S. Piggott Sons
(b) Address 7110 Belair Rd
19 (a) (b) Huntington Williams, M.D. Registrar

JUN 5 1944

VS 11.50

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at 10:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1943, to June 3 1944, and that I last saw h[illegible] alive on June 3 1944.

Immediate cause of death	Duration
Coronary Thrombosis	6/2/44
Preliminary Stenosis	6/3/44
Due to Hypertension Vascular Dis	
Chronic Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fred Erickson M.D.
Address 4 [illegible] Sheldon Rd Date signed 6/5/44

G 17851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G 17851 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 Mosher St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Mosher St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lee Reiter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Frederick Reiter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1865

8. AGE: Years 78 | Months 10 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: George J. Constance
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Adelaide Holland
15. Birthplace: Baltimore

16 (a) Informant: Miss Nettie Reiter
(b) Address: 1825 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery ~~cemetery~~ Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 (a) (Date rec'd by registrar) JUN 5 - 1944 (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1944, to June 1 1944, and that I last saw h~~er~~ alive on June 1 1944.

Immediate cause of death	Duration
Due to Carcinoma of Uterus	4 yrs.
Due to + Bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature: M Bauman Ford M. D.
Address 2200 Garrison Blvd. Date signed 4/5/44

C 17853 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 46B

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 Chestnut Hill Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Chestnut Hill Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Stockhausen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Alverta Hines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Woor worker
11. Industry or business

FATHER
12. Name Emil Stockhausen
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Fritschner
15. Birthplace Germany

16 (a) Informant G. T. Beckstrona
(b) Address 516 Chestnut Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Memorial Park
Location Taylor Ave., Parkville, Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 (a) Filed JUN 5 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1943, to June 2 1944, and that I last saw h/M alive on June 1 1944.

Immediate cause of death: Carcinoma of stomach — Duration: Indefinite

Due to: —

Due to: —

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Sawyer, M.D. M. D.
Address 4808 Harford Road Date signed 6/3/44

G 17853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17853 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1355 N. Calhoun Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 N. Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo A. Young

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1891

8. AGE: Years	Months	Days	If less than one day
52	11	1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Wm Young
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace Md

16 (a) Informant Sarah Young
(b) Address 1355 N. Calhoun St

17 (a) Burial (b) Date thereof 6/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Nat
Location Md

18 (a) Funeral director Geo. B. Nelson
(b) Address 130 Freedman St

19 (a) (b)
(Date received by registrar) Registrar

JUN 8 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3- 19XX, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Woodson M.D.
Medical Examiner.
Date signed 6-3-44

G 17854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1200

Registered No. G 17854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Vincent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elzie Parker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Margaret Parker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months 50 | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Hilda Gales
(b) Address 1914 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1503 Pennsylvania Ave Huntingdon Md

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1944 (month) (day) (year)

21. I certify that death occurred on the date above stated, that I attended deceased from 5/27/44 to 6/2/44 and that I last saw h[illegible] alive on 6/1/44

Immediate cause of death: Peritonitis — Duration 3 days
Due to Gastro Enteritis — 6 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1500 W Baltimore Date signed 6/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 180

3 Copys 17855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

C 17855 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 E. Lafayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 E. Lafayton
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Nathaniel Raymond Sr
3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-16-2947

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Millie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Raymond
13. Birthplace Charles Co Md

MOTHER 14. Maiden Name Emily
15. Birthplace Baltimore

16 (a) Informant Mary Raymond
(b) Address 1243 E Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Md

18 (a) Funeral director Robt E Wilkins
(b) Address 515 N Eden St

19 (a) (Date rec'd by registrar) (b) Huntington W Va Registrar

JUN 5 1944

PS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1944 to 6-1-1944 and that I last saw h[illegible] alive on 6/1 1944

I fix date cause of death

	Duration
Bronchopneumonia	5/25/44
& Pericarditis	5/26/44
Due to	
Arteriosclerosis	2 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature F. R. Blake M. D.
Address 1327 N. Central Ave Date signed 6/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

C 17856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Strieker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Strieker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jules Rogers
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Sidney Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (c) Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Samuel Scott
13. Birthplace Balto Md

MOTHER 14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Aaron Rogers
(b) Address 1308 Strieker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1944 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr Peter R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

JUN 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27/44 to 19..., and that I last saw h... alive on 5/31/44

Immediate cause of death: Coronary Thrombosis

Due to: Senile Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Cecil Bloom M. D.
Address 5 E Read St Date signed 6-7-44

G 17857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183D

G 17857 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Narcisis Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874 [illegible]

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Palmira, N. C.
(Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Columbus Wilson
(b) Address 1802 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) JUN 5 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 7.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944, to June 1, 1944, and that I last saw him alive on June 1 1944.

Immediate cause of death	Duration
Myocardial failure	month
Due to Arterio-sclerosis Hemiplegia (left)	7yrs
Due to Senility	
Other Conditions Chronic complaint	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. W. Pennington M. D.
Address 1632 Druid Hill Ave Date signed 6-5-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17853 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Camel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Camel St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Gulliver

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0861

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23 1899

8. AGE: Years 44 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Samuel Gulliver
13. Birthplace Elmira, N. Y.

MOTHER 14. Maiden Name Martha Smallwood
15. Birthplace Calvert Co. Md.

16 (a) Informant Martha Gulliver
(b) Address 120 Broad St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Hollan
(b) Address 1681 Druid Hill Ave.

19 (a) (b) Registrar

JUN 5 1944 Huntington Mitchell, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1944 at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to June 1 1944 and that I last saw him alive on June 1 1944

Immediate cause of death	Duration
Lobar Pneumonia	10 d.
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Petteraun M. D.
Address 817 Hamilton Ave. Date signed June 7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. C 17859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6501 Baltimore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Vo
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6501 Baltimore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Spencer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife. Isabella Spencer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17 - 1863

8. AGE: Years	Months	Days	If less than one day
81	1	13	hr. min

9. Birthplace England (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name John Spencer
13. Birthplace England

MOTHER
14. Maiden Name Dorathy —
15. Birthplace England

16 (a) Informant Mrs. Dorothea Ohler
(b) Address 6501 Baltimore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 5 44 (month) (day) (year)
(c) Cemetery or crematory Orems
Location Baltimore

18 (a) Funeral director Philip Herurg Sons
(b) Address 2024 Orleans at

JUN 5 - 1944
(Date rec'd by registrar)

Huntington Williams Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1940, to June 2 1944, and that I last saw h[illegible] alive on: June 1944.

Immediate cause of death Chronic myocarditis

Due to myocardial degeneration 6 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Reier M.D.

Address 27 Ensabip Rd. Date signed 6/4/44
Dundalk Md

G 17860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1192 G 17860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 BURGUNDY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy G. Ford.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM. | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 9-1943

8. AGE: Years 1 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace BALTO MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHN FORD
13. Birthplace BALTO MD.

MOTHER
14. Maiden Name AIVNA WATERS
15. Birthplace BALTO MD

16 (a) Informant JOHN FORD.
(b) Address 1124 BURGUNDY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 7-4 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location A. A. Co.

18 (a) Funeral director Bernard C Hoile
(b) Address 121 E West St

(c) Date received JUN 7 1944 (Registrar) Livingston Williams M.D.

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1944 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1944 to 6/3 1944, and that I last saw h[illegible] alive on 6/3 1944.

Immediate cause of death: Delany — Duration 3 hrs.

Due to: Rickets — Duration 2 yrs.

Due to: Tuberculosis entritis — Duration 12 d.

Other Conditions: Lobar pneumonia — Duration 4 wks.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address South Balto Gen'l. Date signed 6-4-44

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[illegible] RESERVED FOR BINDING

G 1786 [illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 1786 [illegible]

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Newburgh (If outside city or town limits, write RURAL and give town)
(d) Street No. 71 Poplar Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Linton Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1911

8. AGE: Years 32 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Newburgh, N.Y. (Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name James Montgomery
13. Birthplace Newburgh, N.Y.

MOTHER
14. Maiden Name Mary Gillespie
15. Birthplace Newburgh, N.Y.

16 (a) Informant Mr. J. Wheeler
(b) Address Newburgh, N.Y.

17 (a) Removal (burial, cremation, or removal) (b) Date thereof 6 8 44 (month) (day) (year)
(c) Cemetery or crematory Newburgh
Location Newburgh, N.Y.

18 (a) Funeral director Wm Cook, Inc.
(b) Address 1213 St. Paul St.

19 (a) [illegible] (b) Huntington Williams, M.D.

JUN 5 - 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1944, at 3:30 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed June 5, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

453264 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G 17857

CERTIFICATE OF DEATH

106B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Clear Spring (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rayetta Moore

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-13-25

8. AGE: Years	Months	Days	If less than one day
18	6	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Dental Asst
11. Industry or business

FATHER
12. Name Stanley Moore
13. Birthplace Md.

MOTHER
14. Maiden Name Nelia Forsythe
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Snyder & Rowland
(b) Address Clear Spring Md

19 (a) (b) Registrar
Date rec'd by registrar JUN 5 1944
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 26 1944 to June 4 1944 and that I last saw him alive on June 4 1944

Immediate cause of death Empyema + Pneumonia — Duration 4 weeks
Due to Bronchiectasis — ? years
Due to
Other Conditions Shock — 20 hrs
(Include pregnancy within three months of death)
Date of operation 4/29/44
Major findings of operations: Bronchiectasis
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence? at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Allen C. Wood Jr. M.D.
Address Johns Hopkins Hospital Date signed 6/7/44

DUPLICATE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17853 / 121 — Registered No. C 17853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Franklin Square Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days): 6
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No.: 21 Lansdowne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William P. McShane

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 216-07-6210

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian M.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 26, 1900

8. AGE: Years: 43 | Months: 5 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Belt. Fan, Ship Yard

FATHER — 12. Name: William McShane

13. Birthplace: Ireland

MOTHER — 14. Maiden Name: Agnes Haley

15. Birthplace: Ireland

16 (a) Informant: Lillian M. McShane

(b) Address: Washington & Elizabeth Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/4/44 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral Cemetery

Location: 4300 Old Frederick Rd.

18 (a) Funeral director: John J. Gowan & Son

(b) Address: 955 & 957 Hollins St.

19 JUN 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1944 at 7.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1944 to 6-1 1944 and that I last saw him alive on 6-1 1944.

Immediate cause of death: generalized peritonitis — Duration:

Due to: Rupt. appendix

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 5-27-44

Major findings of operation: Ruptured appendix & gen. peritonitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Jeburs Gluck

Address: Franklin Square Hosp. Date signed: 6/3/44 M.D.

17854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C 17854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution:
Md. Gen. Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Edmondson Av. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth J. Crutchfield

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife late Clarence C.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 24 1865

8. AGE: Years	Months	Days	If less than one day
78	11	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business at home

FATHER
12. Name Richard Crutchfield
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah Randall
15. Birthplace Baltimore

16 (a) Informant Mr. Richard C. Crutchfield
(b) Address 108 Cherryfield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) JUN 5 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944, to June 2 1944, and that I last saw her alive on June 1 1944.

Immediate cause of death — Duration
Cerebral hemorrhage
Due to
Due to
Other Conditions
Fracture of right femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-10-44 at ? M
(c) Where did injury occur? 3022 Edmondson Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped at home & fell.
23. Signature John D. Young Jr. M. D.
Address Md. Gen. Hospt. Date signed

VS 150 For S-N-L-Mollenweber, by Howard J. Morris, M.D. June 2, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C 17865

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Annapolis Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Annapolis Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1883

8. AGE Years	Months	Days	If less than one day
60	6	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name Martin Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Oakmore
15. Birthplace Germany

16 (a) Informant Mr Charles M Collyer
(b) Address 2901 Annapolis Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave
18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins St

19 (Registrar's signature) Huntington Williams M.D. Registrar

JUN 5 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 19 to June 3 1944.
and that I last saw h alive on June 1 1944

Immediate cause of death Coronary Thrombosis

Duration
1 mo.
8 mos
2 yrs

Due to pulmonary Embolism

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth Lemmon M. D.
Address 2209 Hollins Ferry Rd Date signed 6/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 17866 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2214 Mura St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Mura St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paulina F. Schaaf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Geo H. Schaaf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11, 1876

8. AGE: Years 68 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER 12. Name Unknown

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Germany

16 (a) Informant Mr. Geo H. Schaaf.

(b) Address 2214 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore.

Location Loch Raven & North Ave.

18 (a) Funeral director John F. Howerton Son

(b) Address 906 E. Baltimore St.

19 JUN 5 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1944 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944 to June 3 1944 and that I last saw h[illegible] alive on June 3 1944

Immediate cause of death: Cerebral Apoplexy — Duration: 3 days

Due to: Cerebral Arteriosclerosis — ?

Due to: Senility

Other Conditions: Chr. Endocarditis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 2007 E. Baltimore St. Date signed 6/11/44 M D

VS 150

G 17867

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 17867 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 N. Stricker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-31-1877

8. AGE: Years	Months	Days	If less than one day
67	-	4	hr. min.

9. Birthplace Charles County Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER — 12. Name	Geo. Hawkins
FATHER — 13. Birthplace	St. Mary's Co. Md.
MOTHER — 14. Maiden Name	Mary J. Carter
MOTHER — 15. Birthplace	Md.

16 (a) Informant Samuel Hawkins
(b) Address 819 N. Carey Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-44 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem
Location Baltimore Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) JUN 5 - 1944 (Date rec'd by registrar) Hamilton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 7:30 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed June 5, 1944.

VS 151

C 17863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

C 17863 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 W. 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 W. 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida V. Brosa.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Joshua D. Brosa
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1884

8. AGE: Years 59 60 | Months 9 | Days 16 | If less than one day: hr. min.

9. Birthplace Hanover Pa. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Wm Babylon.
13. Birthplace Pa

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Joshua D. Brosa.
(b) Address 319 W. 27th St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof June 7 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location Woodlawn, Md.

18 (a) Funeral director C. Hanover Smith & Hanover Inc.
(b) Address 2615-17 Eastern Ave.

19 (a) Huntington Williams, M.D. Registrar
(Date received by Local Registrar) JUN 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to June 4 1944
and that I last saw H. alive on June 4 1944

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis CVD. + Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 4 Yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Shumate M. D.
Address 371 Dallas Date signed 6-5-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17069-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4260 - 6th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4260 - 6th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E Backus

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1862

8. AGE: Years 81 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Emma J. Gronk
(b) Address 4260 - 6th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Tilburn Bros Inc
(b) Address 1219 Park Ave

19 (a) JUN 5 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 5 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to 6/3/ 1944, and that I last saw h er alive on 6/3/ 1944:

Immediate cause of death: Broncho-pneumonia. — Duration: 24 days

Due to

Due to

Other Conditions: Hypertensive cardio vascular disease. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weiss M. D.
Address 1226 Hanover St. Date signed 6/5/ 1944

Huntington Williams, M.D.

G 17870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓64

Registered No. G 17870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 Crest Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Crest Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Schaeffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1944

8. AGE: Years | Months 32 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Francis B. Schaeffer,
13. Birthplace Westminister, Md.

MOTHER
14. Maiden Name Erma Seitz,
15. Birthplace Baltimore, Md.

16 (a) Informant Francis B. Schaeffer,
(b) Address 2410 Crest Road

17 (a) Burial (b) Date thereof 6/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore County,

18 (a) Funeral director L. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) Huntington Williams, Registrar
(Date rec'd by registrar) JUN 5 1944

V8461

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1944, at 10 A.M. 05

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicus
lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert H. Graham M.D.
Medical Examiner.
Date signed June 4 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered before you write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G 1707 | BALTIMORE CITY HEALTH DEPARTMENT | G 1707

CERTIFICATE OF DEATH

Registered No. 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hospital (If not in hospital or institution, give street address or location)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. Calvert & Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country 404 S. 3rd St.

3 (a) FULL NAME Baby Girl Perry — 401327

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1944

8. AGE: Years | Months | Days | If less than one day: 3 hr. 25 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Odis Perry
13. Birthplace Alabama

MOTHER
14. Maiden Name Meriffe Bishop
15. Birthplace Alabama

16 (a) Informant Odis Perry
(b) Address 404 South 3rd St. Attalla Ala.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto. Md.

18 (a) Funeral director George A Farber
(b) Address Fulton & Fayette

19 (a) (To be fill'd by registrar) (b) Huntington Williams, M.D.

JUN 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944 at 5.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1944, to May 28 1944 and that I last saw h/M alive on May 28 1944

Immediate cause of death Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Ziegler M. D.
Address Date signed

G 178.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G 17873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joe Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 W. 24th St (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Michael Joseph Garvin

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 213-10-1380

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ANNA B. CARVIN

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) MAR 22-1883

8. AGE: Years 61 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation MOTORMAN

11. Industry or business BALTO. TRANSIT

FATHER
12. Name — CARVIN
13. Birthplace IRELAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace IRELAND

16 (a) Informant MRS. ANNA B. CARVIN
(b) Address 16 W. 24TH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 6-1944 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director J. Evans Sons Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) JUN 5 - 1944 (Date rec'd by Registrar) (b) Washington Wilkins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3- 1944, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27-1944, to 6-3-1944, and that I last saw him alive on 6-3-1944

Immediate cause of death Carcinoma of larynx — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: carcinoma of larynx, squamous cell type, posterior to larynx

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanni, M.D.
M. D.
Address St Jos. Hosp Date signed 6-3-1944

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 17823 G 17823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 133a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct... age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 W. Baltimore
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Coutin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: late Margaret nee Buckingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1885

8. AGE: Years 58 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name G. B. Coutin
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Robert Coutin
(b) Address 1071 Brocot st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Welsh
(b) Address 1101 E Monument Ave.

19 (a) JUN 5 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5 1944, at 1 70 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1944 to 6-5 1944 and that I last saw h/im alive on 6-5 1944

Immediate cause of death P pelonephritis — Duration 2 mo
Due to uremia — 1 wk
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Block M. D.
Address Franklin Square Hosp. Date signed 6-5-44

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gilbert Bruce Shewell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1940

8. AGE: Years 3 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James H. Shewell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elsie Toomey
15. Birthplace Balto, Md

16 (a) Informant James H. Shewell
(b) Address 2306 Sidney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Weitzke
(b) Address 4101 E. Lanvale St.

19 (a) 1944 (Date filed by registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at 7 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to June 3 1944 and that I last saw him alive on June 3 1944.

Immediate cause of death: Congenital Heart Disease — Duration: days Birth

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schonfeld

Address 301 Ampelt Date signed 6/5/44

C 17875 PFEETZ

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 17875 / 170 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 James ST (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward W. Pfeltz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1879

8. AGE: Years	Months	Days	If less than one day
64 57	9	32	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Flor Finisher

11. Industry or business

FATHER
12. Name Gustav
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Price
15. Birthplace Md.

16 (a) Informant Mrs. Chas W. Hannigan
(b) Address 1334 James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. Fairlawn

18 (a) Funeral director Harry A. Fetter
(b) Address 1101 Edmondson Ave.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) JUN 5 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1944, at 6 45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 19-3
(a) Date of injury June 3rd 1944 5-20 P M.
(b) Where did injury occur? Pratt & Stricker Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Lee Gratton M.D. Medical Examiner.
Date signed June 4 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. Type or write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17875 X V 937 Registered No. 037875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Biney + Fairmont Ave.
(c) Hospital or institution: Church Home & Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County —
(c) City or town Quakake (If outside city or town limits, write RURAL and give town) 5
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Lamabell Donat

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mr. Frank Donat
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): June 6, 1882
8. AGE: Years 61 | Months 11 | Days 28 | If less than one day — hr. — min.
9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business: —

MOTHER | FATHER
12. Name: not known
13. Birthplace: Pennsylvania
14. Maiden Name: Katherine Brill
15. Birthplace: Pennsylvania

16 (a) Informant: daughter Mrs. Walter Bennett
(b) Address: 8131 Cornwell Road, Dundalk Md
17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 6-6-44 (month) (day) (year)
(c) Cemetery or crematory: Odd Fellows
Location: Tamaqua - Pa
18 (a) Funeral director: Steward Mooney Co.
(b) Address: 1 [illegible] Ave Huntingdon Milwaukee, Mich.

JUN 6 1944 (Date Registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to June 4 1944, and that I last saw her alive on June 4 1944.

	Duration
Immediate cause of death: Myocardial Infarction	2 days
Due to: arteriosclerotic disease H.D.	?
Due to:	
Other Conditions: cardiac failure	?

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address: Church Home Hospital Date signed 6/5/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 17877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Fayette Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Sheridan

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) --

8. AGE: Years about 78 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace -- (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name --
13. Birthplace --

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mr. J. Kemper
(b) Address 2908 Ridgewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 6 - 1944 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1944, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at....M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed June 5, 1944.

VS 151

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. 17878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and name town)
(d) Street No. 1821 N. Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Wisong

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1860

8. AGE: Years	Months	Days	If less than one day
83	5	17	hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business

FATHER
12. Name: Jacob Wisong
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary Jane Deuring
15. Birthplace: Balto.

16 (a) Informant: Mrs. Mary Hartje
(b) Address: 5204 Wesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUN 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1944, at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Hanging by rope

Due to:

Other Conditions: Mental Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 4, 1944 3:35 P.M.
(b) Where did injury occur? 1821 N. Eutaw St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Hung himself in cellar

23. Signature H. L. Dallenbach M.D. Medical Examiner.
Date signed June 5, 1944

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G 17879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Whittemore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widow

6 (b) Name of husband or wife Edw. Whittemore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-17-70

8. AGE: Years	Months	Days	If less than one day
73	10	16	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Abraham Cohen
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Spier
15. Birthplace Germany

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

19 (a) JUN 6 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 10 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Gas Gangrene (Welch Bacillus) infection — Duration 7 weeks

Due to

Due to

Other Conditions Arteriosclerosis, Diabetes (Include pregnancy within 3 months of death)

Date of operation Gangrenous leg

Major findings of operation: 4/15/44

of autopsy: None Performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr. M.D.
Address Johns Hopkins Hospital Date signed 6/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 17880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 E. 25th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH D. HAMILTON FERGUSSON

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Oscar A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/1879

8. AGE: Years	Months	Days	If less than one day
65	3	6	hr. min.

9. Birthplace Charles Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Edward Hamilton
13. Birthplace Charles Co.

MOTHER
14. Maiden Name Cecelia P. Miles
15. Birthplace Charles Co.

16 (a) Informant Mr. Oscar Ferguson
(b) Address 225 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received) JUN 6 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3/ 1944, at 3:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1938, to June 3, 1944, and that I last saw h[er] alive on June 3 1944.

Immediate cause of death Carcinoma of ovary — Duration 18 months

Due to

Due to

Other Conditions Ventral hernia (post-operative) — Duration 6 years.
(Include pregnancy within 3 months of death)

Date of operation April 2-3, 1943

Major findings of operation: Carcinoma of ovary with ascites

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M. D.

Address 12 E. Eager St. Date signed June 6, 44

C 17881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a

Registered No. C 17881

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in Hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 W. North ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Oscar P. Coleman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1871

8. AGE: Years 72 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Balto. Transit Employee

11. Industry or business

MOTHER / FATHER

12. Name Royal B. Coleman

13. Birthplace Hudson, N. Y.

14. Maiden Name Annabelle Hyland

15. Birthplace St. Michaels, Md

16 (a) Informant Miss Mary E. Coleman

(b) Address 1612 W North ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md

18 (a) Funeral director Wm. J. Tuckner & Son

(b) Address Baltimore, Md.

JUN 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1944, to 6-3 1944, and that I last saw him alive on 6-3 1944

Immediate cause of death Pulmonary edema — Duration

Due to Cardiac failure

Due to Heart Block

Other Conditions Pleural effusion

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Thomas Brennan M. D.

Address St Joseph Hospital Date signed 6-3-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17892 V C 17892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

YA-87875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Patapsco Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Voyce (Myrtle May Voyce)

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-22-9471

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1894

8. AGE: Years	Months	Days	If less than one day
50	2	6	hr. min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Southway Tavern

FATHER
12. Name Thomas Voyce (d)
13. Birthplace Md. (Oxford)

MOTHER
14. Maiden Name Amanda Moon (d)
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 6/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto Md

19 JUN 6 - 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Reg'r)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2 1944 at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1944 to 6-2 1944 and that I last saw h[illegible] alive on 6-2 1944

Immediate cause of death	Duration
Carcinoma Cecum	7
Due to Anaemia Secondary	?
Due to Cachexia Insufficiency	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald B Webb M. D.
Address Balto City Hosp Date signed 6-3-44

17883 17883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46F

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3819 Mt. Pleasant Ave. Ward) 26

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR.

2. FULL NAME Sarah Green

(a) Residence: No. 3819 Mt. Pleasant Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Green

6. DATE OF BIRTH (month, day, year) 842

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Wilmington, Del.

FATHER

13. NAME James Clark

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country) ?

17. INFORMANT James Clark
(Address) 3819 Mt. Pleasant Ave.

18. BURIAL, CREMATION, OR REMOVAL Burial
Place Oak Lawn Cem. Date 6/7 1944

19. UNDERTAKER John J. Duda
(Address) 2829 Hudson Street

JUN 6 - 1944 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 3, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 3 1944 to June 3 1944

I last saw h. alive on June 3 1944 Death is said to have occurred on the date stated above, at 11½ p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Liver	Jan 1944
Other contributory causes of importance: Decubitus	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) L. V. Negus Jr. M. D.

(Address) 1520 E 33rd St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

17884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ C 17884

Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1362 N. Stockton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D. and give No.)
(d) Street No. 1362 N. Stockton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene S. Albert

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 18 1870

8. AGE: Years 73 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob B. Weaver
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Eliza L. Floyd
15. Birthplace N. J.

16 (a) Informant Mr. William Weaver
(b) Address 1362 N. Stockton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)

(c) Cemetery or crematory Lobeserty Cemetery
Location Baltimore Maryland

18 (a) Funeral director William J. Tuffgen & Son
Address Baltimore Maryland

19 (a) JUN 6 - 1944 (Date rec'd by registrar) (b) Huntington Mitchell, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1944, at 6:10 P. M.

21. I certify that I took charge of the remains described above, held an Inquisitory thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardiovascular - renal disease.
Due to Pulmonary Edema.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski, M.D. M.D.
Medical Examiner.
Date signed June 5, 1944.

For C. J. Lubinski, by Thomas J. Watkins, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17835 12B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 McPhail st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 McPhail st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Elizabeth Cassatt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband William Cassatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16th 1920

8. AGE: Years	Months	Days	If less than one day
23	7	18	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name William A. Stockum

13. Birthplace Md

MOTHER 14. Maiden Name Miriam Cassat

15. Birthplace Pa.

16 (a) Informant William A. Stockum

(b) Address 156 McPhail st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ W. S. National

Location Balto, Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

JUN 6 - 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 1944, at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to June 4 1944, and that I last saw h[illegible] alive on June 1 1944.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions Pregnancy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 3151 Walbrook Date signed 6/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200 C

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Elwood
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ Yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6423 Glen Oak Ave (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Wattin Phoebus Jr (Wm.W.Phoebus Jr.)

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. .....
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 2 6 44
8. AGE: Years ..... Months 4 3 Days 28 If less than one day ..... hr. ..... min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name William W. Phoebus
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Louise L. Reid
15. Birthplace ~~Balto~~ West Virginia

16 (a) Informant Father
(b) Address 6423 Glen Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.
18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.
19 (a) ..... (b) ..... Registrar

JUN 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 3.25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1944, to June 4 1944, and that I last saw him alive on June 4 1944.

Immediate cause of death: Cardio Respiratory Failure — Duration .....
Due to ? — .....
Due to ? — .....
Other Conditions ? — .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....
23. Signature William H. Leffler M. D.
Address Union Memorial Hosp. Date signed 6/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

JL - 87580

CERTIFICATE OF DEATH

Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Mercer

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Harry (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1859

8. AGE: Years 85 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Mason
13. Birthplace Md.

MOTHER
14. Maiden Name Sara ? ~~Allen~~ Allen
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig & Sons
(b) Address 2024 Orleans St.

19 (a) Filed (b) Registrar
JUN 6 1944
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 1944 to 6/4 1944.
and that I last saw h[illegible] alive on 6/4 1944.

Immediate cause of death	Duration
Bronchopneumonia	?
Due to: ~~Cerebral Hemorrhage~~ Heart Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dave Mattman
Address B. C. H. Date signed 6/5/44 M.D.

C 17838 ✓ C 17833

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1184 Cleveland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1184 Cleveland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Spillman

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Bertha Teglow Spillman
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Dec 14 1883

8. AGE: Years	Months	Days	If less than one day
60	5	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Geo W. Spillman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katie Poston
15. Birthplace Baltimore Md

16 (a) Informant Mrs William B. Spillman
(b) Address 1184 Cleveland St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location 2930 Pedrick Ave

18 (a) Funeral director John F Cowan & Son
(b) 1600 Gallows St

19 (a) JUN 6 1944 (Date rec'd by registrar) (b) Thos Dayton Williams, M.D. Address 1 W Mt Vernon Pl

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1944, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 19 44 to 6/3 19 44 and that I last saw h[illegible] alive on 6/3 19 44

Immediate cause of death: Acute Cardiac Failure — Duration 6/3/44
Due to: Cerebral Arteriosclerosis Renal Disease — 3yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Lankantz M.D.
Date signed 6/3/44

VS 150

G 17880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 17880
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Bond
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Slater Saunders
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-14-1906
8. AGE: Years 38 Months 3 Days 18 If less than one day hr. min.
9. Birthplace Florida (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fred Slater
13. Birthplace Virginia

MOTHER
14. Maiden Name Effie Henry
15. Birthplace Georgia

16 (a) Informant Victoria Slater
(b) Address 105 S. Bond

17 (a) Burial (b) Date thereof 6/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a.g. to md

18 (a) Funeral director Isaiah T. Brown & Son
(b) Address 108 W Montgomery St

19 (a) JUN 6 - 1944 Huntington Williams, M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to June 2 1944 and that I last saw h[illegible] alive on June 2 1944.

Immediate cause of death: Acute Myocarditis — Pulmonary edema — Duration: 2 Days

Due to: Cerebral Thrombosis — 1 Day

Due to: Acute Hypertension — 17 Years

Other Conditions: ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 6-3-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. 90

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S Exeter St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Isaac Rudolf
13. Birthplace Russia

MOTHER
14. Maiden Name Sophie Brominger
15. Birthplace Russia

16 (a) Informant Frank Levin
(b) Address 2552 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

JUN 6 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

3.30

20. DATE OF DEATH June 6 1944, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1944, to 6/6 1944, and that I last saw h[illegible] alive on 6/5 1944

Immediate cause of death — Duration
Acute Bronchopneumonia
Due to Ch myocarditis
Due to Ch Hypertention
Other Conditions Parkinsons Disease

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Aisquith Date signed 6/6/44

G 1789 G 1789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12 9 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 E Twenty Eighth St.
(c) Hospital or institution: ********
(d) Length of stay in hospital or inst. (yrs., mos., or days) *****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 E Twenty Eighth St. (If rural give location)
(e) Citizen of foreign country? *** (Yes or No)
If yes, name country

3 (a) FULL NAME John Charles Kelly.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-7807

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude (McNaney) Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1895.

8. AGE: Years	Months	Days	If less than one day
48	10	25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Plumbing Work

FATHER
12. Name John Kelly
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Buck
15. Birthplace Baltimore Md.

16 (a) Informant Gertrude M Kelly
(b) Address 1801 E Twenty Eighth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director J Melville Jenkins
(b) Address 2715 Kirk Ave

19 (Date received by registrar) JUN 6 - 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1944, at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1943, to June 3 1944, and that I last saw her alive on June 3 1944.

Immediate cause of death Pneumonary Tuberculosis — Duration 8 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S B A Stevens M. D.
Address 3878 Harford Rd Date signed 6-5-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 17892 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 S. Ann Stree t
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Lorenz

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 220-07-1537

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1867

8. AGE: Years	Months	Days	If less than one day
76	10	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman-retired 8 yrs.
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name George Lorenz
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Danhardt
15. Birthplace Germany

16 (a) Informant Elizabeth Lorenz
(b) Address 206 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar) JUN. 6 - 1944

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH June 3 1944, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1944 to June 3, 1944, and that I last saw him alive on June 2 - 1944.

Immediate cause of death	Duration
Diabetes Mellitus	10 years
Due to	
Due to	
Other Conditions Enlarged Prostate Gland	1 month

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cassagne M. D.
Address 514 Drury Lane Date signed June 5 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C 17893

C 13503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4611 Asbury Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County - -
(c) City or town Baltimore - 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4611 Asbury Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CALVIN BENJAMIN COOPER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sue H. Cooper
6 (c) If alive, give age 89 years

7. Birth date of deceased (mo., day, yr.) Oct. 28. 1857

8. AGE: Years 78 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired Cabinetmaker
11. Industry or business C. & P. Telephone Co.

FATHER
12. Name George W. Cooper
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Eliza Clark
15. Birthplace England

16 (a) Informant Mrs. Sue H. Cooper
(b) Address 4611 Asbury Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7. 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 JUN 6 1944 (d) Filed Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4. 1944 at 5.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to June 4 1944, and that I last saw him alive on June 1 1944.

Immediate cause of death: Uraemia due to Hypertension
Due to Nephritis
Due to Contributing cause
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration: ? | | | Jan 19 44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno R Williams M. D.
Address 2627 E Monument Date signed 6/5 44

17894 NOVACK G 17894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave Calhoun to
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Fulton Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Novack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 - 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph F. Novack
13. Birthplace Penna

MOTHER
14. Maiden Name Alzura V. Postol
15. Birthplace Penna

16 (a) Informant Joseph F. Novack
(b) Address 211 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6 1944 (month) (day) (year)
(c) Cemetery or crematory Catholic Cem
Location City

18 (a) Funeral director Roth & B. M. Walter Co.
(b) Address Pratt & Stricker Sts

19 JUN 6 - 1944 (Date rec'd by local reg.) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2-44 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2-44 19... to 6-2-44 19..., and that I last saw him alive on 6-2-44 19...

Immediate cause of death: Brain Atelectasis — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings: Brain Atelectasis
Of operations: Hemorrhagic adrenal gland
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Clyde Webster
Address Franklin Sq. Hosp. Date signed 6/5/44 M. D.

VS 3

C 17895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V C 17895

931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. 30 St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucielle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22 - 1898

8. AGE: Years 45 | Months 5 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Gray

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Tirsia Gray

15. Birthplace Balto. Md

16 (a) Informant Mrs. Grace Gray

(b) Address 300 - E - 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Md. Avenue

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Belnord Ave

19 (a) (Date rec'd by registrar) (b)

JUN 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944 to June 3 1944, and that I last saw ... alive on June 3 1944

Immediate cause of death: Chronic Myocarditis

Due to: Pulmonary Heart Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. J. Banfield

Address Provident Hospital Date signed 6/3/44

C 17896 ✓ C 17896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 Amity St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Vine St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23

8. AGE: Years	Months	Days	If less than one day
50	11	9	hr. 18 min. 93

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George V. Wilson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Holbrook
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. George V. Wilson
(b) Address 822 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-44 (month) (day) (year)
(c) Cemetery or crematory Sound
Location Balto. City

18 (a) Funeral director Mrs. Katie F. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) JUN 6 1944 (b) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1944, at 11.45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hughes S. McNally M.D. Medical Examiner.
Date signed 6/3/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17637 C 17637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

YA-88802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4604 Mannasota Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Hoen or Carl Hoehn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1887

8. AGE: Years	Months	Days	If less than one day
56	10	-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business Unemployed

FATHER
12. Name William Hoen (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Litchey (d)
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6th 1944 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location East North Ave Ext

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by registrar) (b) Washington Heights, Md.

VS JUN 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 1944, at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1944 to 6/3 1944 and that I last saw h[illegible] alive on 6/3 1944

Immediate cause of death Uremia
Due to Nephritis chronic
Due to Cirrhosis of Liver

Duration
?
?
?

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattme M.D.
Address B. Q. 14 Date signed 6/5/44

C 17893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. C 17893

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden Ave. & Madison St.
(c) Hospital of institution: Wd. Devil Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 772 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Paul Petri Sr. (Petri)

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. 218-09-4396

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jennie C. Petri

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1870

8. AGE: Years 73 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Stock Clerk

11. Industry or business: Bartlett, Hayward Co.

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Miss. Minnie A. Petri
(b) Address: 772 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: Geo. W. Little
(b) Address: 2700 Edmondson Ave.

19 Filed JUN 6 - 1944 by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6/44 19 , at 1 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1944 to 6/6 1944, and that I last saw h[illegible] alive on 6/5 1944

Immediate cause of death	Duration
Coronary occlusion	
Due to: C. V. D.	?
Due to:	
Other Conditions: Ca of rectum	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. H. Traynor M. D.
Address: Wd. Devil Hosp. Date signed 6/6/44

C 17839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C 17839

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Pulaski St
(c) Hospital or institution: No. B. St. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) X days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 North Eutaw
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Solomon D. Vogel

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1873

8. AGE: Years	Months	Days	If less than one day
70	6	25	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Cigar
11. Industry or business Maker

FATHER
12. Name Maier Vogel
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah Castine
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Lillie V. Gross
(b) Address 2300 Eutaw Place

17 (a) Burial (b) Date thereof 6/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Maier Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (c) Huntington Williams, Mgr

JUN 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5/44 19 .. at 6.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2/44 19 .. to 6/5 19 44
and that I last saw him alive on 6/5/44 19 ..
Immediate cause of death Coronary Thrombosis — Duration 6 Days.
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Irving J. Taylor
Address W. Balto. Md. Date signed 6/6/44

C 17900 C 17900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1735 W. North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Louis Pimes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ wife: Henrietta S. Pimes | 6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29 1867

8. AGE: Years: 76 | Months: | Days: 6 | If less than one day: hr. ..... min.

9. Birthplace: England (Town, county, and state)

10. Usual Occupation: Cigar maker

11. Industry or business:

FATHER: 12. Name: Solomon Pimes
13. Birthplace: Poland

MOTHER: 14. Maiden Name: Cecelia Letterman
15. Birthplace: Germany

16 (a) Informant: Mrs. A. Caplin
(b) Address: 1735 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/7/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Hebrew Friends Soc.
Location: Balto. Md.

18 (a) Funeral director: Harid Sonnheim Son
(b) Address: 902 Eutaw Place

19 JUN 6 - 1944 Washington Hollands, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1944, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1944 to June 4, 1944, and that I last saw him alive on June 4, 1944.

	Duration
Immediate cause of death: Cardiac tamponade	
Due to: Myocardial infarction	
Due to: Coronary occlusion	
Other Conditions: Cerebro vascular accident.	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Hemopericardium

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.....

23. Signature: Dwork
Address: Sinai Hosp. Date signed: 6/5/44

G 17901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 17902 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Univ. Balto. Gen'l Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fredrick E. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-5331

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Caroline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7th 1880

8. AGE: Years	Months	Days	If less than one day
63	5	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Lock Insulator

FATHER
12. Name John Miller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Fogel
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Pfaff
(b) Address 1723 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location 3000 Edmondson Ave.

18 (a) Funeral director William M Yarech
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 6 1944 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 2.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1944 to 6/4 1944 and that I last saw h[illegible] alive on 6/4 1944

Immediate cause of death Hypertensive c-v. disease. — Duration

Due to

Due to

Other Conditions

(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel
Address 1726 Hanover St Date signed 6/7/44 D.

G 17362 G 17363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution West Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip Baitch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Aaron Baitch

13. Birthplace Russia

MOTHER 14. Maiden Name Isaacs —

15. Birthplace Russia

16 (a) Informant Jos. Baitch (Son)

(b) Address 444 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location Herman Hill Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Harrington Williams, M.D. Registrar

JUN 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1944, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1944 to 6/6 1944, and that I last saw him alive on 6/6 1944.

Immediate cause of death: Terminal pneumonia — Duration 4 days

Due to Metastatic Cancer

Due to Ca of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.

Address W. B. G. H. Date signed 6/6/44

G 17963 G 17963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital of Baltimore, Inc. Rutland Ave

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2117 Patterson Park Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Louis Kalvert

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-4443

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 Months Days If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER: 12. Name

13. Birthplace Russia

MOTHER: 14. Maiden Name

15. Birthplace Russia

16 (a) Informant Louis Pearlman

(b) Address 2400 Liberty Hgts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)

(c) Cemetery or crematory Workmen Circle

Location Jack Levin & Co 1739 E. Baltimore St

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar) (b)

VS 1 JUN 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944, to June 5 1944, and that I last saw h[illegible] alive on June 5 1944

Immediate cause of death	Duration
Cachexia	
Due to Carcinomatosis	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation [redacted]

Major findings of operation: Carcinoma

of autopsy: Carcinoma

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harold Rilton

Address Sinai Hosp Date signed 6/5/44

b 17904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. C 17904

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5037 Chalgrove Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 57-99
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5037 Chalgrove Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Rubel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Herman Rubel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Sugar
13. Birthplace Russia

MOTHER
14. Maiden Name Lena —
15. Birthplace Russia

16 (a) Informant Herman Rubel
(b) Address 5015 Chalgrove Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-44 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle
Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St

19 (a) (Date received by registrar) JUN 6 1944 (b) Huntington Mitchell, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1942 to June 5, 1944, and that I last saw h alive on May 17, 1944

Immediate cause of death Metastasis to lungs — Duration

Due to Chondro-Sarcoma of Right Scapula

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-20-42 - 3-1-43

Major findings of operation: Chondro-Sarcoma - confirmed by microscopic sections

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Clarence Cohn M.D.
Address 3801 N. Charles St Date signed 6/6/44

C 17305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V848

C 17305

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 144 N. Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1835 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Offney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1888

8. AGE: Years	Months	Days	If less than one day
56	2	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Anthony Tribull
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Karl
15. Birthplace Balto. Md.

16 (a) Informant Anna Teichman
(b) Address 144 N. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Edgewood Ave

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address 1[illegible] Lombard & Ann Sts.

19 (c) JUN 6 - 1944 Washington Millicent, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944 to 6/4 1944 and that I last saw her alive on 6/4 1944

Immediate cause of death Respiratory failure — Duration

Due to Malnutrition

Due to

Other Conditions Schizophrenia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Abrafsky MD

Address 601 N. Kenwood Ave Date signed 6/6/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G 17906

YA-87691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 George St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1876

8. AGE: Years	Months	Days	If less than one day
67	5	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Waters
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 1631 Druid Hill Ave.

JUN 6 - 1944 (Date received) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2 1944, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1944, to 6-2 1944, and that I last saw h[illegible] alive on 6-2 1944.

Immediate cause of death	Duration
Uremia	
Due to Benign Prostatic Hypertrophy	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Hebb
Address Balto City Hosp Date signed 6-3-44 M. D.

C 17907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195E

C 17907 Registered No. 7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 691 Pierce Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Dickerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Clanton Co. S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Dickerson
13. Birthplace S.C.

MOTHER 14. Maiden Name Julia Demute
15. Birthplace S.C.

16 (a) Informant Robert A. Dickerson
(b) Address 809 Jackson St. Winston Salem N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)

(c) Cemetery or crematory
Location Pinewood, S.C.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1800 Bryant Ave

19 (a) JUN 6 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 3 1944 26/4 M.
(b) Where did injury occur? Canton R.R. Co. Canton
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? yes
(d) Means of injury Struck by falling wood

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 4 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17508 G 17508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days) about 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt St Agnes Convent
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Gonzaga Martin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1- 1864

8. AGE: Years	Months	Days	If less than one day
80	0	5	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business —

FATHER
12. Name Philip Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne —
15. Birthplace Ireland

16. (a) Informant Sister M. Celeste
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. St Agnes Cemetery
Location Mt Washington

18 (a) Funeral director H. W. Meissesson
(b) Address 805 N. Calvert St.

19 JUN 6 - 1944 (b) Registrar
Filed by

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944, at 12.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2nd 1943, to June 6 1944, and that I last saw h[illegible] alive on June 6 1944.

Immediate cause of death	Duration
Cardiac failure	22 hrs
Due to Coronary Thrombosis	72 hrs
Due to	
Other Conditions Lobar Pneumonia Suppurative Intestinal Obstruction.	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/15
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 2 1943 at 12 Noon M
(c) Where did injury occur? Catonsville Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Mt St Agnes Convent While at work? No
(Specify type of place)
(e) Means of injury Fell on floor.
23. Signature Robert J. Berry
Address Mercy Hospital Date signed 6/6/44 M D Y
Howard J. Andersen, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C 17909 Registered No.

2611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 S.CLINTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 S.CLINTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHRISTINE WINTERLING

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: CONSTANTINE WINTERLING
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC.5 1859

8. AGE: Years 84 | Months 6 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name ALBERT PROTZMANN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant FRANK WINTERLING (SON)
(b) Address 3301 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 9/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler INC
(b) Address 403 S.WOLFE ST.

19 (a) JUN 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 5 1944, at 5/40 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944, to June 5 1944, and that I last saw her alive on June 5 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 47 days
Due to: Arterio-sclerosis — years
Chronic bronchitis — years
Due to: Coronary thrombosis — 1 day
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Bronusha, M. D.
Address 3037 O'Donnell St. Date signed June 6, M. 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

453267 C 1791O

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 51d

C 1791O Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town HICKORY (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 S. 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Mc DANIEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 1 - 28 - 14

8. AGE: Years 30 | Months 4 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Textile WORKER

11. Industry or business

FATHER
12. Name John S. McDaniel
13. Birthplace Tenn.

MOTHER
14. Maiden Name Myrtle Speagle
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ~~Hickory~~ Burial (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sandis Lutheran
Location Hickory, N. C

18 (a) Funeral director Leonard Black
(b) Address 1205 Hanford Road

(a) (b)

JUN 5 1944 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 6 1944. at 515 A M

21. I certify that death occurred on the date above stated; that I attended deceased from APR 26 1944. to JUNE 6 1944. and that I last saw HIM alive on JUNE 6 1944.

Immediate cause of death Brain Tumor — post operative. | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 27, 1944

Major findings of operation: Surgical tumor — ?. fibroid.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lew W. Chambers

Address Johns Hopkins Hosp Balto. Md. Date signed 6/6/44

C 17911

AB-88093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

C 17911

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1623 Latrobe St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Jones-Twin B

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Marshall Jones

13. Birthplace S.C.

MOTHER

14. Maiden Name Viola Brown

15. Birthplace Fla.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 3Pm-6-2-1944 (month) (day) (year)

(c) Cemetery or crematory BaltimoreCity Hospitals

Location 4940 Eastern Ave, Baltimore-Md.

18 (a) Funeral director

(b) Address

JUN 6 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20- 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 1944, to 5/20 1944, and that I last saw her alive on 5/20 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to premature labor prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H B Perry, Jr. M.D. M. D.

Address Balt city Hosp Date signed 5/31/44

VS 150

263141 17913 G 17913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 N Chapel St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jeff Pettiford
3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	married

6 (b) Name of husband or wife Sally
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 9 1901

8. AGE: Years	Months	Days	If less than one day
43	2	14	..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Squire Pettiford
13. Birthplace ? N.C.

MOTHER
14. Maiden Name Candese Bradshaw
15. Birthplace N.C.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Roxborough
Location N. C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

(a) JUN 6 1944 (Registrar) (b) [signature] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1944 at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1944 to 6/3 1944 and that I last saw him alive on 6/3 1944

Immediate cause of death Bronchial Asthma — Duration .....
Due to .....
Due to .....
Other Conditions Pulmonary Tbc Emphysema
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature [signature] M. D.
Address Johns Hopkins Hosp Date signed 6/7/44

G 17913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17913

Registered No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Fairfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1371 Binder Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gracie M. Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/1938

8. AGE: Years 5 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Bailey, N. C.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Clough Hughes
13. Birthplace S. C.

MOTHER
14. Maiden Name Lilly Mae Raines
15. Birthplace S. C.

16 (a) Informant Lilly Mae Hughes
(b) Address 1371 Binder Ct.

17 (a) Burial (b) Date thereof 6-8-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

JUN 6 - 1944 (b) Huntington Williams, M.D.
(Local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5, 1944, at 4 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns, 1st, 2nd, 3rd degree, body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-29-44 at 9 A.M. 25/6 M.
(b) Where did injury occur? 1371 Binder Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Was playing with fire - Clothes became ignited.

23. Signature H. L. Wallenmeier M.D.
Medical Examiner.
Date signed June 5, 1944.

G 17914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Brookfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Rosenfeld

3 (b) If veteran, name war —

3 (c) Social Security Account No. 088-10-0925

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Bessie.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business

FATHER
12. Name Frank
13. Birthplace Russia.

MOTHER
14. Maiden Name Gar
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof 6-6-44 (month) (day) (year)
(c) Cemetery or crematory Mountain View Long Island New York City
Location

18 (a) Funeral director Jack Leuzler
(b) Address 1439 E. Baltimore St.
(c) (b) Baltimore, Md.
(Date received by registrar) JUN 6 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5-1944, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/29/44 at 3 A M.
(b) Where did injury occur? Smaltz ave, nr York Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Struck with blunt instrument.

23. Signature Howard J. Malpeis M.D.
Medical Examiner.
Date signed 6-6-44

C 17915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

C 17915 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin W. Vinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-3466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 4 1909

8. AGE: Years	Months	Days	If less than one day
34	7	2	hr. min.

9. Birthplace Goldsboro N.C. (Town, county, and state)

10. Usual Occupation Machinist for
11. Industry or business Middleton Co, 11 E Lee St

FATHER
12. Name Benjamin J Vinson
13. Birthplace N C

MOTHER
14. Maiden Name Betty Hair
15. Birthplace N.C.

16 (a) Informant Mrs W. H. Carter
(b) Address Goldsboro N C R. - 2

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Goldsboro Cemetery
Location Goldsboro N. C.

18 (a) Funeral director William M Mare
(b) Address 715 East Fayette St

19 (a) JUN 6 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 6 - 1944, at 4 45 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4-1

(a) Date of injury 6-4-44 at 4:30 P. M.
(b) Where did injury occur? Franklin St. & St. Paul St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No (Give details)
(d) Means of injury Passenger, auto - collision

23. Signature Howard J. Wadsworth M.D. Medical Examiner.
Date signed 6-6-44

G 1791 6 G 1791 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-4-37
(e) Length of stay in Baltimore (yrs., mos., or days) 2-4-37

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Portsmouth (If outside city or town limits, write RURAL and give town)
(d) Street No. St Paul's Rectory (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rt. Rev. Msgr. Francis Joseph Magri

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1868

8. AGE: Years	Months	Days	If less than one day
75	6	14	hr. min.

9. Birthplace Lynchburg, Virginia (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name Francis Joseph Magri
13. Birthplace Italy

MOTHER
14. Maiden Name Mary McCarron
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Lynchburg Va
Location " "

18 (a) Funeral director Stewart Mowen & Co
(b) Address 1058 Northern Ave.

19 (a) JUN 6 - 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944, at 6.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1942 to June 6 1944, and that I last saw him alive on June 1944.

Immediate cause of death: Rt Lo Pneumonia — Duration: 4 days

Due to:

Due to:

Other Conditions: Involutional Psychosis - melancholia — Duration: 2 years
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian P. Murphy M. D.
Address 33 Westminster Date signed

Thurlington Williams, M.D.

C 17917 C 17917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 528

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3915 Southern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3915 Southern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA WILLIAMS

3 (b) If veteran, name war
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15,1877

8. AGE: Years	Months	Days	If less than one day
67	0	19	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Kiefer,
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Fredericka Helm,
15. Birthplace Balto., Md.

16 (a) Informant Mrs. C. Luerssen,
(b) Address 3915 Southern Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June8,1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Loranbe Funeral Home
(b) Address 7401 Belair Road

JUN 6 - 1944 (Date rec'd by registrar) Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 1944, at 4:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943 to June 4 1944, and that I last saw her alive on June 3 1944

Immediate cause of death

	Duration
Carcinoma of bladder	9 mos.
Due to	
Due to	

Other Conditions Secondary anemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Lee Hiebert
Address 4116 Northern Pkwy Date signed 6/6/44

A. Lee Hiebert

C 17918 — C 17918

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. C 17918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 N. Duncan
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N. Duncan (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William O'Petty

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary O'Petty

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 9, 1871

8. AGE: Years 73 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Country Tipperary (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business Hospital

FATHER: 12. Name Thomas O'Petty
13. Birthplace Country

MOTHER: 14. Maiden Name Not Known
15. Birthplace Country

16 (a) Informant Mary Ann O'Petty
(b) Address 723 N. Dudley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Md

18 (a) Funeral director Frank Brooks Son
(b) Address 900 N. Eutaw St

19 (a) JUN (b) Huntington, Md. (Signature of city registrar)

JUN 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to June 4 1944 and that I last saw him alive on June 4 1944

Immediate cause of death: Hypostatic Pneumonia — Duration 6/1/44

Due to: Chronic Myocarditis — 1/1/43

Due to: Arterio Sclerosis — 1939

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Ryder M. D.

Address 801 N Kenwood Ave Date signed 6/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. C 17919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 8 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2781 The Alameda (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Margaret D. Smith (Margaret Dorothy Smith)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: 212-22-7708

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jay C. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1892

8. AGE: Years	Months	Days	If less than one day
51	6	22	hr. min.

9. Birthplace: Clarion, Pa. (Town, county, and state)
10. Usual Occupation: Inspector
11. Industry or business: Bendix

FATHER
12. Name: -- Arnold
13. Birthplace: unknown

MOTHER
14. Maiden Name: unknown
15. Birthplace: unknown

16 (a) Informant: Mr. Jay C. Smith
(b) Address: 2781 The Alameda

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/6/44 (month) (day) (year)
(c) Cemetery or crematory Swickley Heights
Location Township, Alleghany Co. Pa.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.
(c) (Date received by Registrar) Thurlington Williams, M.D. Registrar

JUN 7 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1944, at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1944 to 6-6 1944, and that I last saw her alive on 6-6 1944.

Immediate cause of death: Acute Yellow atrophy of liver — Duration: 4 wks
Due to
Due to
Other Conditions Chole-lithiasis

(Include pregnancy within 3 months of death)
Date of operation 6-2-44
Major findings of operation: Above
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address Md. Gen. Hosp. Date signed 6-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. C 42920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2538 McHenry Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2538 McHenry St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Smith

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George A. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 21, 1853

8. AGE: Years 91 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name James Merriken
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amanda Broughton
15. Birthplace Baltimore Md.

16 (a) Informant Amanda T. Schulz
(b) Address 253 E McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Ave.

19 JUN 7 - 1944 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 5 1944, and that I last saw h.er alive on Jun 3 1944.

	Duration
Immediate cause of death: Cardiac Vascular Nephritis	1 wks.
Due to: Arterio-sclerosis	year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature W. Benjamin Hood M. D.
Address 2206 Jarrett Blvd Date signed 6/5/44

VS-150

G 17921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

Registered No. G 17921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1117 Somerset St
(b) Street address Balto, Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1117 Somerset St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-18-7089

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	widow

6 (b) Name of husband or wife Ernine Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 1897

8. AGE: Years	Months	Days	If less than one day
47	3		hr. min.

9. Birthplace Lunenburg, Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Marshall
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Va.

16 (a) Informant Marie Hatcher
(b) Address 147 Somerset st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7-1944 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md

18 (a) Funeral director Benj. Francis H. Wright
(b) Address 721 Aisquith St

19 (a) (Prepared by registrar) (b) [illegible] Registrar, M.D.

June 7 - 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1944, at 9:05 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Fatal death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gastric Ulcer.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. L. Wallenmeyer M.D.
Medical Examiner.
Date signed June 2, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17822

AB-88225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 83a

C 17822 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3240 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 207 W. Hamburg St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward. Skinner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1879

8. AGE: Years	Months	Days	If less than one day
65	2	30	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer (Pennsylvania R.Road)

11. Industry or business

FATHER

12. Name James T. Skinner (D)

13. Birthplace Md.

MOTHER

14. Maiden Name Frances Freeland (D)

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Co., Md.

18 (a) Funeral director Josiah L. Brownlow

(b) Address 10 S W Montgomery St

JUN 7 - 1944 (Date rec'd by Local Registrar)

(b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-2 1944, at 6 TO A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1944 to 6-2 1944 and that I last saw him alive on 6-2 1944

Immediate cause of death	Duration
Cerebral Accident	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattern M. D.

Address B. C. H. Date signed 6-5 44

VS 160

C 17923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 17823 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Westwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15-10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM FRANCIS LEAGUE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: None
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maud Lillian League
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 18, 1865
8. AGE: Years 78 | Months 6 | Days 16 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Balto. Schools, Retired

FATHER
12. Name John League
13. Birthplace ?

MOTHER
14. Maiden Name Emma Rose
15. Birthplace ?

16 (a) Informant Mr. Howard J. Hughes
(b) Address 3627 Marriott Lane, Rockdale
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) JUN 7 - 1944 (Date rec'd by registrar)

Dwight Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH June 4, 1944, at 11:00M
21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1944 to June 4 1944
and that I last saw him alive on June 4 1944

Immediate cause of death: Chr. Nephritis — Duration: ?
Due to: Generalized atherosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Howard J. Hughes, M.D.
Address 3921 Edmondson Ave Date signed 6/7/44

G 17924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 159

Registered No. G 17924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Height
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Calderhead

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-6-44. 1 hr 15 min
8. AGE: Years | Months | Days | If less than one day: hr. 15 min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Calderhead
13. Birthplace Chicago Illinois

MOTHER
14. Maiden Name Margaret Louise Fitch
15. Birthplace Kansas City, Missouri

16 (a) Informant John Calderhead
(b) Address Linthicum Hghts Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
Address 1217 St. Paul St.

19 (a) JUN 7 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1944, to 6-6 1944 and that I last saw him alive on 6-6 1944.

Immediate cause of death	Duration
Premature - 5 mos.	
Due to Placenta Previa	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Huntington Williams, M.D.
Address Bon Secours Hosp. Date signed 6/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. C 17925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 Caswell st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Hanover st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Arnildt

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry C. Arnildt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1862

8. AGE: Years 81 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name (Unknown) Walter
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant George C. Arnildt
(b) Address 107 W. 5th Ave. Brooklyn Park

17 (a) Burial (b) Date thereof 6/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location "Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St Paul st

JUN 7 - 1944
(Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1944, at 9.10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944, to June 5 1944, and that I last saw h~~er~~ alive on June 4 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Ed Stevens
Address 478 Hanford Rd Date signed 6/9/44

17926

P.G.P.--82787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 G

Registered No. G 17926

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:-
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 16
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lynch

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1881

8. AGE: Years	Months	Days	If less than one day
62	6	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William A. Lynch
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Holland
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address [illegible] Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Carmel
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JUN 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1943, to 6-6 1944, and that I last saw h[illegible] alive on 6-6 1944.

Immediate cause of death: Pulmonary Tb. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mettee
Address B.C.H. Date signed 6/6/44

17927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Reg. or C. 17927

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4924 Wilbur Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah F. Grissom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lamar Grissom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1919.

8. AGE: Years: 24 | Months: 7 | Days: 15 | If less than one day: hr. min.

9. Birthplace Meadow View Va.
(Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business Camp Holabird

FATHER
12. Name S. D. Moore
13. Birthplace Va

MOTHER
14. Maiden Name Viola Arnett
15. Birthplace Va.

16 (a) Informant Lamar Grissom
(b) Address 4924 Wilbur Ave Armistead Gardens

17 (a) Funeral (b) Date thereof 6/7/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Harrison
Location Roanoke Va

18 (a) Funeral director Tilhom Lee Dix
(b) Address 1214 Light St

19 (a) Filed JUN 7 1944 (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION 55

20. DATE OF DEATH June 6 1944, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944, to June 6 1944, and that I last saw h. e. r. alive on June 6 1944

Immediate cause of death: Pulmonary edema — Duration:
Due to: Cardiac failure
Due to: Hypertensive Cardio-Vascular disease
Other Conditions: Chronic nephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan, M. D.
Address St Joseph Hospital Date signed 6-6-44

C 17928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

C 17928 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave 1511
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Segovia Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Annette Kissela

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David Kissela
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Beverly Lieberman
15. Birthplace Baltimore Md

16 (a) Informant David Kissela
(b) Address 3100 Segovia Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

Filed JUN 7 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1944, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1944, to 5/28 1944 and that I last saw h[illegible] alive on 5/28 1944

Immediate cause of death	Duration
Cardiac failure	
Bronchopneumonia	
Due to Congenital Heart	
Due to	
Other Conditions Atelectasis?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond B. Fielding M. D.
Address Sinai Hosp Date signed 5/29/44

VS 3

0994

C 17929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. C 17929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Sts
(c) Hospital or institution Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½
(e) Length of stay in Baltimore (yrs., mos., or days) 5½

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Gilmore Bryden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1944

8. AGE: Years	Months	Days	If less than one day
		5½	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name William Gilmore Bryden
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Anna Marie Stohr
15. Birthplace Baltimore Md

16 (a) Informant Anna Marie Bryden
(b) Address 2822 Ashland Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 7 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

0995

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1944 at 9:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to May 16 1944 and that I last saw h alive on 19

Immediate cause of death Bronchopneumonia, Pneumonia

Due to

Due to

Other Conditions Premature Birth

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Bronchopneumonia, Pneumonia, Congenital Hypoplasia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond B. Privette, M. D.
Address Sinai Hosp. Date signed 6/6/44

G 17930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161B

Registered No. G 17930

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby girl Peaks
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: BLACK | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 23-44

8. AGE: Years | Months | Days 1 week | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Oakley Peaks
13. Birthplace VA

MOTHER 14. Maiden Name Bertha Ford
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JUN 6 1944 Commissioner of Health

18 (a) Funeral director
(b) Address

19 JUN 7 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 31 1944, at 5:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 30 1944, to MAY 31 1944, and that I last saw h e alive on MAY 31 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: Sepsis of newborn.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ellis Fair M. D.
Address 601 N. Broadway Date signed 5-31-44

VS 250

0996

C 17931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17931 Registered No.

YA-82789

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos. 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Carnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Katie-?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1890

8. AGE: Years 54 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unable to get further information

11. Industry or business

FATHER
12. Name Thomas Carnes (d)
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Margaret Gross (d)
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location [illegible] JUN 6 1944

18 (a) Funeral director [illegible]
(b) Address 321 Brookfield

19 JUN 7 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2- 1944 at 10.15A

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-43 to 6-2- 1944 and that I last saw him alive on 6-2- 1944.

Immediate cause of death: Cerebral Accident — Duration: 2

Due to: Hypertensive Cardio Vascular Lesion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattina M.D.

Address R.C.H. Date signed 6/3/44

10997

G 17832

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JO 88190 — Registered No. 121 — G 17832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of wife Maggie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
53 ?	?	?	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Louis Simmons
13. Birthplace North Carolina

MOTHER
14. Maiden Name Caroline ?
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 JUN 7 1944 (Date rec'd by Registrar) (b) Harlan Lee Williams, M.D. Registrar

UNIVERSITY MEDICAL SCHOOL JUN 6 1944 Commissioner of Health

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1944, at 5:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1944 to 5/29 1944, and that I last saw h[illegible] alive on 5/29 1944.

Immediate cause of death: Ruptured aneurism with peritonitis — Duration: 7

Due to

Due to

Other Conditions: Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autopsy by above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattma M. D.
Address B.C.H. Date signed 5/29/44

0998

G 17933

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

JO #86951

CERTIFICATE OF DEATH 46 B

G 17933 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Salvation Army (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1888

8. AGE: Years 56 | Months -0- 1 | Days 10 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Isom Hill
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mariah Horn
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 7 1944 (Date rec'd by registrar) (a) Huntington Williams, M.D. Registrar

VS 150

0999

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1944, at 6:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1944 to 5-28 1944 and that I last saw h(im) alive on 5-28 1944.

Immediate cause of death: Carcinoma of Stomach — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattine M.D.
Address B.C.H. Date signed 6/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17934 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Kingsway Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Kingsway Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ferdinand Dreeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1250

8. AGE: Years	Months	Days	If less than one day
93	11	20	hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation Furniture Finisher
11. Industry or business

FATHER
12. Name William Dreeman
13. Birthplace Germany

MOTHER
14. Maiden Name Theodora Pflick
15. Birthplace Germany

16 (a) Informant James O Bromwell
(b) Address 1609 Kingsway Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location O'Donnel St Balto Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

JUN 7 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1944 to 6/5 1944, and that I last saw h[im] alive on 6/5/44 19

Immediate cause of death Rt. Congestive Heart Failure — Duration

Due to Arteriosclerotic CVHD

Due to Generalized Arteriosclerosis

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applegate
Address 2511 Reisterstown Rd Date signed 6/6/44 (M/D)

Approved by Howard J. Moreis, M.D.

G 17935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G 17935 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
Baltimore, Md. W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 354 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ethyl E Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30 1885

8. AGE: Years	Months	Days	If less than one day
58	98	6	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Clements
13. Birthplace Md

MOTHER
14. Maiden Name Mary Potts
15. Birthplace Md

16 (a) Informant Thomas B Miller
(b) Address 354 S Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 JUN 7 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1944, to 6-5 1944, and that I last saw her alive on 6-5 1944

Immediate cause of death Respiratory failure
uremia

Due to Lymphosarcoma
pyelitis

Due to Metastatic Carcinoma
Cervix of pentineal cavity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-20-44

Major findings of operation: metastatic Ca of cervix

of autopsy: See Cause of death.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Mye Carpenter M.D.
Address Univ. Hosp. Date signed 6-8-44

454199
G 17936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

G 17936 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. Amer (b) County
(c) City or town Medillin
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paulina Toro (Paulina M. de Toro)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Canato

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 12-24-90

8. AGE: Years 53 | Months 5 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace S. A. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jose Maria Martinez
13. Birthplace S.A.

MOTHER
14. Maiden Name Paulina Santamaria
15. Birthplace S.A.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-44. (month) (day) (year)
(c) Cemetery or crematory Medillin
Location Columbia - S. America

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) (Date received by registrar) JUN 7 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944, to June 4 1944, and that I last saw her alive on June 4 1944.

Immediate cause of death	Duration
Pulmonary embolus	
Due to	
Due to	
Other Conditions Carcinoma of rectum, post operative. (Include pregnancy within 3 months of death)	

Date of operation 5-25-44
Major findings of operation: Carcinoma of rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. McLean M. D.
Huntington Williams, M.D. Johns Hopkins Hosp. Date signed 6-9-44

C 17837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17837 Registered No. 195E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bells, Md.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Druid Hill ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Boyd.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-03-4346

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1904

8. AGE: Years 39 | Months 9 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Reedsville, S. C. (Town, county, and state)

10. Usual Occupation Helper

11. Industry or business

FATHER
12. Name Lewis Boyd
13. Birthplace S. C.

MOTHER
14. Maiden Name Cora
15. Birthplace S. C.

16 (a) Informant Pauline Boyd
(b) Address 1619 Lormak Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George L. Nelson
(b) Address 803 Presstman St

19 (a) ____ (Date received by registrar) (b) Huntington Williams, Registrar

VS Form JUN 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6- 1944, at 12-05 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-6-44 at 478 1650 A M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Undetermined

23. Signature Howard J. Sheldon M.D. (Medical Examiner.)
Date signed 6-6-44

C 17938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C 17938
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Nagel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles T. Nagel
6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1869

8. AGE: Years: 75 | Months: 4 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Home Duties

11. Industry or business

FATHER
12. Name: Christian Eitemiller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary E. Koenig
15. Birthplace: Baltimore, Md.

16 (a) Informant: Charles T. Nagel
(b) Address: 2884 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 7, 1944 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge
Location: Elkridge, Md.

18 (a) Funeral director: Wm. H. Sprecher & Son
(b) Address: 713 W. Lombard St

19 (a) JUN 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1944, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944, to 6/5 1944, and that I last saw alive on: 19

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Arterial Sclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Charles Nagel M. D.
Address: 2145 W. Balto St Date signed

G 17939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17939 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4609 Mary Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4609 Mary Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Pines

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Alice George Pines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1867

8. AGE: Years	Months	Days	If less than one day
76	11	28	hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)
10. Usual Occupation Eng. Sta. Retired 28yrs.
11. Industry or business

FATHER: 12. Name ? Pines
13. Birthplace Unknown

MOTHER: 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. M. Stanley
(b) Address 4609 Mary Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave & Broadway

19 (a) (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

JUN 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1944 19 7.57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944 to June 4 1944
and that I last saw him alive on June 4 1944

Immediate cause of death
Uremia
Due to Chronic interstitial nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration 14 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin Bonsteel M. D.
Address 5430 Belair Road Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

G 17940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
City or town Baltimore Homeland 27
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME William Emory Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/44.

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None.

FATHER
12. Name Earl Edwin Braun
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Wilson Barnett
15. Birthplace Ebna, Md

16 (a) Informant Mrs Emma Braun
(b) Address Wynsdowne, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto. Co.

18 (a) Funeral director Harry H. Wetzler
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 7 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1944, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1944, to 6/6 1944, and that I last saw him alive on 6/6 1944.

Immediate cause of death	Duration
Heart Failure	
Due to Congenital Heart Disease.	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Patent Ductus Arteriosus Patent Interventricular Septum Pulmonary Stenosis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight D. Kalb.
Address Hosp. Date signed 6/7/44

C 17841 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

C 17841

Registered No. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 20y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Sharp St (If rural give location)
(e) Citizen of foreign country? ~ (Yes or No)
If yes, name country ~

3 (a) FULL NAME Matthew CARTER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1901

8. AGE: Years 42 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Salisbury N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Carter
13. Birthplace N.C.

MOTHER 14. Maiden Name Rebecca Pedrie
15. Birthplace N C

16 (a) Informant Madalin Hollins
(b) Address

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof 6/7/44 (month) (day) (year)
(c) Cemetery or crematory Salisbury
Location N C

18 (a) Funeral director Daniel L Brantley
(b) Address 1024 W Montgomery

6-7-1944 (Date rec'd by registrar) (b) [redacted] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1944 to 6/4 1944 and that I last saw him alive on 6/4 1944.

Immediate cause of death	Duration
Hemolytic anaemia	
Due to chronic glomerulo nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M. D.
Address South Balt Hosp Date signed 6-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

G 17942 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 W. University Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELSYE BOYD METTEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Holmes I. Mettee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1885

8. AGE: Years	Months	Days	If less than one day
59	3	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Boyd
13. Birthplace Balto.

MOTHER
14. Maiden Name Adele Councilman
15. Birthplace Balto.

16 (a) Informant Mr. Holmes I. Mettee
(b) Address 104 W. University Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

(a) JUN 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1944 at 3:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1943 to May 5 1944, and that I last saw h.w. alive on May 5 1944

Immediate cause of death	Duration
myocardial collapse	2 days
Due to Quinine intramuscularly + arterio sclerosis + C.P.C.	3 yrs. —
Due to with general anasarca.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Burman and Lund M. D.
Address 2200 Garrison Blvd Date signed 6-1-44

C 17943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 17943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Belle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. WREDE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hannah E. Wrede
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/7/1871

8. AGE: Years	Months	Days	If less than one day
72	11	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Conductor
11. Industry or business B. & O. R. R.

FATHER
12. Name August Wrede
13. Birthplace Germany

MOTHER
14. Maiden Name Mata ?
15. Birthplace Germany

16 (a) Informant Mrs. Hannah E. Wrede
(b) Address 3902 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received JUN 7 - 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1944, at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1944 to 6/5 1944; and that I last saw h[illegible] alive on 6/5 1944.

Immediate cause of death	Duration
Bright's Disease	1 yr.
Due to Pneumonia	4 days
Due to Coronary artery	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: X
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Hearn M. D.
Address 7901 Harrison Date signed 6/10/44

G 17944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 17944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 W. Garrison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 W. Garrison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT H. HORNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie E. Horner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1853

8. AGE: Years	Months	Days	If less than one day
90	5	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Albert H. Horner
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline C. Smith
15. Birthplace Md.

16 (a) Informant Mrs. Charles H. Gibson, Daughter
(b) Address 3810 W. Garrison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 7 1944 (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1943. to June 6 1944. and that I last saw h. alive on June 4 1944.

Immediate cause of death	Duration
Myocarditis	2 mo.
Due to Arterio sclerosis (advanced)	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Tickner M. D.
Address 2220 Garrison Blvd Date signed June 6/44

G 17945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 123 Registered No.

G 17945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Annex Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Annesley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Este Montague Clapham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M.

6 (b) Name of husband or wife Richard Clapham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2-1894

8. AGE: Years 49 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Elva B. Montague

13. Birthplace Accomac Co. Va.

14. Maiden Name Cornelia E. Harding

15. Birthplace Harford Co.

16 (a) Informant Richard L. Montague

(b) Address 734 Annesley Rd.

17 (a) Burial (b) Date thereof June 8-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Union Chapel
Location Wilna, Harford Co.

18 (a) Funeral director John G. Hillan

(b) Address 4201 Greenmount Av

JUN 7-1944
(Date rec'd by registrar)

(c) Registrar Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to June 5 1944, and that I last saw h[illegible] alive on June 5 1944.

Immediate cause of death Acute Circulatory failure — Duration 15 hrs.

Due to Interfascial obstruction parlys — 7 days

Due to Adhesions

Other Conditions Jejunal ulcer of Gangrenous intake (Include pregnancy within 3 months of death)

Date of operation May 31 1944

Major findings of operation: Jejunal ulcer & gangrene of intestine Intestinal tract

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert L. Berry M. D.

Address Mercy Hospital Date signed 6/5/44

C 17946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

Registered No. C 17946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1872.

8. AGE: Years 72 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace Long Island, N.Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Stancliff
13. Birthplace Unknown

MOTHER
14. Maiden Name Alice Dodge
15. Birthplace Unknown

16 (a) Informant Mrs. Barbara Globe
(b) Address 521 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 8 - 44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Cem.
Location Taylor Ave. Balto. Co., Md.

18 (a) Funeral director L. Heemann and Son.
(b) Address 32 S. Broadway

19 (a) JUN 7 - 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION 30

20. DATE OF DEATH June 6, 1944, at 5 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 7 1944

G 17947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

G 17947 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 3039 E. Monument St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME George J. Conrad

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-4062

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1903

8. AGE: Years	Months	Days	If less than one day
40	5	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Auto. Painter

11. Industry or business

FATHER

12. Name George J. Conrad Sr.

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Pauline King

15. Birthplace Balto. Md.

16 (a) Informant Marie Cole

(b) Address 507 N. Glover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9/44 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location North Ave. & Gay St.

18 (a) Funeral director John H. Miller

(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUN 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5-1944 at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17-1944 to 6-5-1944, and that I last saw him alive on 6-5-1944.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to Subdiaphragmatic abscess	
Due to Ruptured peptic ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-17-44

Major findings of operation: Ruptured peptic Ulcer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank L. Vannig M.D. M. D.

Address Br. Jos. Hosp. Date signed 6-5-44

C 17948 U.S.C.P. 88862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 17948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city limits, write RURAL)
(d) Street No. 1600 E. Biddle St. 4940 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cleary, Harvey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? Year 1912

8. AGE: Years	Months	Days	If less than one day
32	?	?	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Cleary
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Jones
15. Birthplace Virginia

16 (a) Informant: Baltimore City Hospitals
(b) Address Records

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 9 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto. County Md.
18 (a) Funeral director Mrs Robert A. Elliott Dyer
(b) Address 429 N. Caroline St.
19 (a) JUN 7 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1944 1944 at 8:15 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1944 to 6-5 1944 and that I last saw h[illegible] alive on 6-5 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Mattman
Address B.O.H. Date signed 6/6/44

G 17949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G 17949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Bayless St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. [redacted] Kanely.

3 (b) If veteran, name war V

3 (c) Social Security Account No. 210-09-2525

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A. Kanely

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1889.

8. AGE: Years 54 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Maintenance, at

11. Industry or business American Agricultural Chem. Co

FATHER
12. Name John A. Kanely
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catharine Gagler
15. Birthplace Md.

16 (a) Informant Arthur Kanely
(b) Address 3413 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1308 Eutaw Place

19 (a) 1944 (Date received by registrar) (b) [illegible]

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944 at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to carbon monoxide
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 6 1944 at M.
(b) Where did injury occur? 1017 Bayless St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Inhaled gas from oven

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed June 6 1944

C 17950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

C 17950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605. N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N Carrollton Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Deborah Grace Howard
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Fem
5. Color or race Col
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alfred Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 Months Days If less than one day hr. min.

9. Birthplace Carthage - N.C (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George. W. Kelly
13. Birthplace Carthage - N.C.

MOTHER
14. Maiden Name Josephine Kelly
15. Birthplace Carthage - N.C.

16 (a) Informant Alfred Howard
(b) Address 605 N. Carrollton Ave

17 (a) Burial (b) Date thereof 6-6-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Registrar

JUN 7 1944 Huntington Williams, MD
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1944 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 6/2 1944 and that I last saw h[illegible] alive on 6/2 1944.

Immediate cause of death Acute Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. N. Patterson M.D.
Address 1775 Pulaski Hwy Date signed 6/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17951 - 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1-W-Franklin St.-
(c) Hospital or institution:
at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 04
(e) Length of stay in Baltimore (yrs., mos., or days) 0yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1-W-Franklin St.
(If rural, give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kreuder Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White -
6 (a) ~~Single, married, widowed, or divorced.~~ Legally Separated
6 (b) Name of husband or wife: Magdalena Kreuder
6 (c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) March 8-1886
8. AGE: Years 58 | Months 2 | Days 28 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Subj to Commissioners for
11. Industry or business opening Streets.

FATHER
12. Name Charles Kreuder
13. Birthplace Germany

MOTHER
14. Maiden Name Margret Schumann
15. Birthplace Germany

16 (a) Informant Mr C.F. Kreuder- (Son)
(b) Address 300 Allendale St-
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore
18 (a) Funeral director Stewart Mourning
(b) Address 102 W York ave.
(c) JUN 7 - 1944 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5- 1944 at 12 PM

21. I certify that death occurred on the date above stated, that I attended deceased from June 1944 to June 5 1944, and that I last saw him alive on May 28 1944

Immediate cause of death: Coronary Occlusion — Duration: 1 Week

Due to: Sclerotic Cardiovascular Renal Disease — Duration: 10 Yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 6-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1795215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 87E

Registered No. G 17952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Bluefield (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Vineyard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Williamson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-26

8. AGE: Years	Months	Days	If less than one day
17	10	11 10	hr. min.

9. Birthplace VA (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Claude Williamson
13. Birthplace VA

MOTHER
14. Maiden Name Addye Cleek
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-44 (month) (day) (year)
(c) Cemetery or crematory Walnut Grove
Location Bluefield W. Va.

18 (a) Funeral director John E. Miller Funeral Home
(b) Address 243 S Main St

19 (a) (Date received by registrar) (b) Huntington, W. Va. Registrar

JUN 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 145 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944, to June 7 1944, and that I last saw her alive on June 7 1944.

Immediate cause of death	Duration
(a) Coronary thrombosis	
Due to (b) Acute edema of pulmonary artery — Rheumatic heart disease	
Due to (c) Aortic regurgitation of Syphilis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/20, 5/22, 5/26, 5/31, 6/5

Major findings of operation: Coronary thrombosis, Hypertrophy of heart, Aortic regurgitation

Date of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul W. Saunders
Address Johns Hopkins Hosp. Balto. Md. Date signed 6/7/44

G 17953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G 17953

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Olivia F. Stevenson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or ~~wife~~ Henry Stevenson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Perrymansville City Md. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business

FATHER
12. Name Peter Stevens
13. Birthplace Perrymansville City Md

MOTHER
14. Maiden Name Annie ?
15. Birthplace Perrymansville City Md

16 (a) Informant Mrs. Annie Gleaves daughter
(b) Address 73 York St Salem N J.

17 (a) Burial (b) Date thereof 6 8 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burial Mt. Lebanon
Location Anne Arundel Co. Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 142 Jefferson St

19 (a) JUN 8 - 1944 Huntington Hillcrest, Md. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5/ 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to June 5 1944, and that I last saw her alive on June 4 1944.

Immediate cause of death Carcinoma Cervix — Duration

Due to — Duration

Due to — Duration

Other Conditions Generalized Carcinomatosis Edema and Bladder — Duration
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph J. Young
Address 1424 Edmondson Date signed 6/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G 17954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3910 Duvall Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Duvall Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PRISCILLA JANE WHALEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Franklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1857

8. AGE: Years	Months	Days	If less than one day
86	8	2	hr. min.

9. Birthplace Howard Co.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Carr Fulton
13. Birthplace Loudon Co., Va.

MOTHER
14. Maiden Name Mary Eliz. Mercier
15. Birthplace Howard Co., Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 6/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams, M.D.
(Date received by registrar)

JUN 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, at 5:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 15th 1944 to June 6th 1944, and that I last saw h[illegible] alive on June 6th 1944

Immediate cause of death: Heart Failure — Duration: 1 day
Due to: arteriosclerosis — 4 years
Due to: senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J E Poulton
Address 3906 Gwynns Road Date signed 6/7/44

G 17955 ✓ G 1755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1216 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days) 36y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Dr. Edwin Plassnig, M.D.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lucille Plassnig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16-1896

8. AGE: Years 47 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Switzerland (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Aloiz Plassnig
13. Birthplace Switzerland

MOTHER
14. Maiden Name Alma Suedre
15. Birthplace Switzerland

16 (a) Informant Lucille Plassnig
(b) Address 1904 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road-Baltimore

18 (a) Funeral director F. O. Wolfort & Son
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VR JUN 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1944 to 6/6 1944, and that I last saw h[illegible] alive on 6/6 1944

Immediate cause of death: Chronic phlegmonous - mastitis — Duration: 4y.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Oehlen M. D.
Address 2701 N. Calvert St. Date June 6, 1944

C 17956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

C 17956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 Webster ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Webster St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin A. Shiner (Schiner)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Carrie Schiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1875

8. AGE	Years	Months	Days	If less than one day
	68	10	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name (Unknown) Schiner
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace Ireland

16 (a) Informant Catherine Schiner
(b) Address 1726 Webster St.

17 (a) Burial (b) Date thereof 6/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address

19 (a) JUN 8 - 1944 (b)
(Date rec'd by Reg.) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 6 1944

C 17957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

C 17957
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 Franklintown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Franklintown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA C. SCHAUB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife J. Jacob Schaub.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/26/1880

8. AGE: Years	Months	Days	If less than one day
63	8	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home.

FATHER
12. Name Henry Horn
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Klaus.
15. Birthplace Germany

16 (a) Informant Family
(b) Address 106 S. Franklintown

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 6-10-44 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Woodlawn Md

18 (a) Funeral director Kershner Funeral Home
(b) Address 2301 Edmondson Ave

19 (a) JUN 8 - 1944 (Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH June 7, 1944 ~~19~~, at 2 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of neck (cervical Vertebrae)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 7, 1944 1:45 A. M.
(b) Where did injury occur? 106 Franklintown Road
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fell backwards down the stairs

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 7 1944

VS 161

G 17958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17958
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Howard
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.
0	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife unk.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name unk
13. Birthplace

MOTHER
14. Maiden Name unk
15. Birthplace

16 (a) Informant Hospital Adm. Slip.
(b) Address

17 (a) Burial (b) Date thereof 6-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md.

18 (a) Funeral director Mrs. Francis H. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
(Registrar) Registrar

JUN 8 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1944, to 6/6 1944, and that I last saw her alive on 6/6 1944.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Arteriosclerotic - Degenerative Cardio-Vascular Disease	
Due to	
Other conditions Auricular Fibrillation Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Shaal M. D.
Address Univ. Hospital Date signed 6/6/44

G 17959 ✓ G 17959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N Pulaski
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Calvert Lipscomb

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	col	Married

6 (b) Name of husband or wife Otelia Lipscomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11-1893

8. AGE: Years	Months	Days	If less than one day
50	5	24	hr. min.

9. Birthplace Lestermanor Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ewell Lipscomb
13. Birthplace Lestermanor, Va

MOTHER
14. Maiden Name Jennie
15. Birthplace Lestermanor, Va

16 (a) Informant Otelia Lipscomb
(b) Address 1624 Presbury St

17 (a) Burial (b) Date thereof June 8, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Hunting Ave Baltimore Md

JUN 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1944 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1944 to 6/5 1944, and that I last saw h alive on 6/4 1944.

Immediate cause of death Carcinoma of Oesophagus
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
4 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Carcum M. D.
Address 1508 N. Arlington Ave Signed 6/7/44

b 17960 ✓ G 17960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No.

T.G.P. 88308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Orleans Street
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Waters, Joseph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widowed

6 (b) Name of husband or wife Annie Waters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23--(?)87

8. AGE: Years	Months	Days	If less than one day
74(?)	3 ?2	? 11	hr. min.

9. Birthplace Maryland, Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Littleton Watson Waters
13. Birthplace Maryland

MOTHER
14. Maiden Name Amaria Harris
15. Birthplace Maryland

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Williams
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
19 (a) (Date rec'd by registrar) (b) Registrar

VA JUN 8 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1944, at 10:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944, to 6-4 1944 and that I last saw him alive on 6-4 1944

Immediate cause of death	Duration
Uremia	?
Due to Benign Prostatic Hypertrophy	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattman
Address B.C.H. Date signed 6/6/44

G 17961

JO #80077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17961

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3-10

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1621 Argyle Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Brooks (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1888

8. AGE: Years 56 | Months -4- | Days -0- | If less than one day: hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER — 12. Name Major Russ

13. Birthplace Virginia

MOTHER — 14. Maiden Name Ada Boston

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location West Port

18 (a) Funeral director Wm. A. Brooks

(b) Address 1463 N. Carey St

19 (a) JUN 8 1944 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, 1:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1940, to 6-6 1944, and that I last saw h[er] alive on 6-6 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	?
Due to Hypertension and arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattina M.D.

Address B. C. H. Date signed 6/7/44

G 17962 ✓ G 17962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 N. Calvert St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Amanda French Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Edward W. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1860

8. AGE: Years	Months	Days	If less than one day
84	2	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William French
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Woods
15. Birthplace Md.

16 (a) Informant Miss Edna A. Thompson
(b) Address 2200 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to June 7 1944, and that I last saw h alive on June 6, 1944.

Immediate cause of death: Acute Obstruction of Bowels — Duration: 4 days

Due to: Carcinoma of Rectum — Duration: ?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gibson Porter M. D.
Address 4822 Roland Ave. Date signed

G 17963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 17963 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Christopher Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Christopher Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Stein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Stein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 18-1871

8. AGE: Years 73 | Months 3 4 | Days 20 | If less than one day hr. min

9. Birthplace Baltimore Md.
(City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name George Stein
13. Birthplace Germany

MOTHER 14. Maiden Name Henrietta Zeller
15. Birthplace Germany

16 (a) Informant [illegible] Marie Stein
(b) Address 3018 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Fairmount Cem.
Location Balto Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St

19 (a) JUN 8 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1943 to 6/7 1944, and that I last saw him alive on 6/7 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wyeth Talley M.D.

Address 503 Harpst St Date signed 6/8/44

G 17964

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 123

V G 17964 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Macleam St & London Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (~~yrs. mos. or~~ days) 35
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 858 W. 32nd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Charles T. Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth V Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1897

8. AGE: Years 47 | Months — | Days 25 | If less than one day hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER 12. Name Robert Hall
13. Birthplace Ohio

MOTHER 14. Maiden Name Rella Bell Dubois
15. Birthplace Ohio

16 (a) Informant Mr Ferguson
(b) Address Monumental Printing Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 10 44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Memorial
Location Washington Blvd. Balto Md.

18 (a) Funeral director D. L. Covington
(b) Address 21 W 25 St.

JUN 8 - 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 7 1944 at 7 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1944 to 6-7 1944, and that I last saw him alive on 6-7 1944

Immediate cause of death Cerebral thrombosis

Due to Laceration, perforated & generalized peritonitis

Due to

Other Conditions Fecal fistula

(Include pregnancy within 3 months of death)

Date of operation 5-1-44

Major findings of operation: abscess

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H Young Jr. M. D.

Address Md. General Hosp. Date signed 6-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17965
T.G.P.--88780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 17965

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.-2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Conway Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna May Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1914

8. AGE: Years 30 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laundry Worker

11. Industry or business

FATHER 12. Name Richard Smith

13. Birthplace Virginia

MOTHER 14. Maiden Name Jane Smith

15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11, 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary Cemetery

Location Annapolis Junction, Anne Arundel County, Md.

18 (a) Funeral director Joseph A. Lively

(b) Address 4709 Mount Street

JUN 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-[illegible] 1944, to 6-6 1944, and that I last saw [illegible] alive on 6-6 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattman

Address B. C. H. Date signed M 6/7/44 D

G 17966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1166

Registered No. G 17966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside the town limits, write RURAL and give town)
(d) Street No. 821 Arlington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Collins

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 1905

8. AGE: Years	Months	Days	If less than one day
39	2	7	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Laundry

11. Industry or business

FATHER
12. Name Charles Coates
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Carrie Roads
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs. Helen Andrews
(b) Address 815 N. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Tom Am.
Location Baltimore County Md.

18 (a) Funeral director Joseph A. Bicky
(b) Address 469 N. Mount St.

19 (a) JUN 8 1944 (Date received by Local Registrar) (b) Hunting & Williams U.P.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6- 1944, at 11 20 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of chest involving right pulmonary artery
Due to and lung.

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-6-44 at 10.50 M.
(b) Where did injury occur? 821 Arlington ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gun shot wound

23. Signature Howard J. Weldeis M.D.
Medical Examiner.
Date signed 6-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 17967 Registered No. C 17967

C 17967

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fialkowska

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wm. Fialkowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8th 1881

8. AGE: Years 62 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Felix Zamenski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Piechocka
15. Birthplace Poland

16 (a) Informant Mrs. Wm Fialkowski
(b) Address 1618 Eastern Ave.

17 (a) Burial (b) Date thereof 6-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location O'Donnell St. Rd.

18 (a) Funeral director Wm Fialkowski
(b) Address 1618 Eastern Ave.

19 (a) JUN 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 10:5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 44 to June 7 19 44 and that I last saw h[er] alive on June 6 19 44

Immediate cause of death	Duration
Coronary Thrombosis	2 wks
Due to Uremia - Nephritis - Hypertension Cardio-Renal Disease	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Guendler M. D.
Address 76 E. Fayette St Date signed 6/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

Wechselberger C 17968

C 17968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6703 O'Donnell Ste
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6703 O'Donnell Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wechselberger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Susanna (Zapf)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar-16-1863

8. AGE: Years	Months	Days	If less than one day
81	2	19	hr. min.

9. Birthplace Austria (Town, county and state)
10. Usual Occupation Silver Smith
11. Industry or business Retired

FATHER
12. Name Michael Wechselberger
13. Birthplace Germany

MOTHER
14. Maiden Name Uyle
15. Birthplace Germany

16 (a) Informant Mrs. Helen Hock
(b) Address 6703 O'Donnell Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell Ste Rd.

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave.

JUN 8 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944 at 4 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to June 5 1944 and that I last saw h[illegible] alive on June 5 1944

Immediate cause of death Carcinoma of Larynx & Cervical Lymphadenitis — Duration June 2/44

Due to

Due to

Other Conditions Arteriosclerotic C.V. Disease.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 842 S Eutaw Date signed 6-7-44

G 17969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 17969 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Redwood & Green Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1d.

(e) Length of stay in Baltimore (yrs., mos., or days): 1d.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County: Baltimore

(c) City or town: Baltimore, 21 (Essex)
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 423 Riverside Dr. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3 (a) FULL NAME: Baby boy Hoffstetter

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 6-6-44

8. AGE: Years	Months	Days	If less than one day
			20 hr. 15 min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Baby

11. Industry or business

FATHER 12. Name: Mr Calvin Hoffstetter

13. Birthplace: Balto Co.

MOTHER 14. Maiden Name: Anna Horn

15. Birthplace: Balto Co.

16 (a) Informant: Parents

(b) Address: Essex Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 6-44 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn

Location: Eastern Ave. Rd.

18 (a) Funeral director: Jno G. Connelly

(b) Address: 418 Eastern Ave Essex

(Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-6 44 19 , at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1944 to 6-6 1944, and that I last saw h[illegible] alive on 6-6 1944

Immediate cause of death	Duration
Atelectasis	
Due to: Prematurity	20 hrs
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury:

23. Signature: Leroy W Tolbert M.D.

Address: Univ. Hosp., Date signed: 6-7-44

Huntington Williams, M.D.

G 17970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1168

Registered No. G 17970

Every item of information should be carefully supplied. Use black ink and write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY Sulphur Hickman Sr.,

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Plasterer
11. Industry or business

FATHER
12. Name George Hickman
13. Birthplace Maryland.

MOTHER
14. Maiden Name Sarah Morgan
15. Birthplace Baltimore, Md.

16 (a) Informant Harry Sulphur Hickman Jr.
(b) Address 1521 East 35th Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Louden Pk Cemetery
Location Frederick Ave.,

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison Street.

19 (a) JUN 8 - 1944 (Date rec'd by registrar) Wm. H. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 05

20. DATE OF DEATH June 7, 1944 1944, at 1 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May 27xx, 1944 11:32 P. M.
(b) Where did injury occur? In front of 1800 E. Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck during altercation and knocked to ground

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 7 1944

17971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13-B Registered No. B 17971

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 da
(e) Length of stay in Baltimore (yrs., mos., or days) ? 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County ?
(c) City or town ? (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Street

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-44

8. AGE: Years	Months	Days	If less than one day
0	3	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William Street
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Moore
15. Birthplace Virginia

16 (a) Informant Sydenham Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1020 Bank Ley

19 (a) JUN 8 1944 (Date rec'd by registrar) Huntley for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6-44 19 at 10.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 19 44 to 6-6 19 44 and that I last saw her alive on 6-6 19 44.

Immediate cause of death Miliary tuberculosis — Duration more than 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: miliary tbc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed

G 17972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 17972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town: Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 South Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MOLLIE BOWEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	MARRIED

6 (b) Name of husband or wife JOHN BOWEN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 21 1892

8. AGE: Years	Months	Days	If less than one day
51	9	17	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant JOHN BOWEN (HUS.)
(b) Address 608 S. WASHINGTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 12/44 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) JUN 8 1944 (b) Registrar
Date Received
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1944, at 4 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed June 7 1944

G 17973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17973 Registered No. 131a

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 Cole St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 W. Hamburg St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen B. Leisure

3 (b) If veteran, name war ----
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband xxxx George O. Leisure
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1871

8. AGE: Years 73 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Harry Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Whittey
15. Birthplace Md.

16 (a) Informant Mrs. Mildred E. Horst
(b) Address 1606 Cole St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

JUN 8 1944 (b) Huntington Miller Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, at 1.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3, 1942, to 6/6/ 1944, and that I last saw her alive on 6/5/ 1944.

Immediate cause of death	Duration
Chronic interstitial nephritis, hypertensive cardio	
Due to vascular disease	2 yrs
Due to	
Other Conditions Uraemia	2 weeks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Leisel M. D.
Address 1226 Hanover St. Date signed 6/6/44

G 17974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 17974

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution: Balto Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 4
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Lynch Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Willmina L Lynch

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife James B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1870

8. AGE: Years 74 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Md N.Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name William Longdon
13. Birthplace N.Y.

MOTHER 14. Maiden Name Elizabeth Pye
15. Birthplace N.Y.

16 (a) Informant Charles E. Lynch
(b) Address Lynch Rd. Dundalk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Baltimore

18 (a) Funeral director Wm Cook Jnr.
(b) Address 1217 E Paul Street

JUN 8 - 1944 (Date received by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 1944 to 6-8 1944.
and that I last saw her alive on 6-5 1944.

Immediate cause of death Carcinoma Colon
Duration ?
Due to Carcinoma of Liver.
Due to Died on operation
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6-5-44
Major findings of operation: see above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address Univ. Hosp. Balto. Date signed 6-9-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 17976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

C 17975
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5908 Benton Hgts Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5908 Benton Hgts Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lee Gotch Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1870

8. AGE: Years	Months	Days	If less than one day
73	5	22	hr. min.

9. Birthplace Baltimore, Co. Md.
(Town, county, and state)
10. Usual Occupation Quarry man
11. Industry or business

FATHER
12. Name Thomas B. Gotch
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Josephine Forrester
15. Birthplace Balto. Co. Md

16 (a) Informant Mrs. Martha M. Gotch
(b) Address 5908 Benton Hgts Ave.

17 (a) Burial (b) Date thereof 6.10.44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard Kyle
(b) Address 5305 Harford Rd

19 (a) Filed by registrar 6-11-44 (b) Registrar

JUN 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1944, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1941, to June 6 1944, and that I last saw him alive on June 6 1944.

Immediate cause of death	Duration
Adeno-carcinoma	
Due to Ruptured	17 hours
Due to with malarias	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Benson M. D.
Address 1 W. Overlea Ave Date signed 6/7/44

G 17976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

G 17976 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Stanwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Stanwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa A. Powley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edwin C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18 1862

8. AGE: Years	Months	Days	If less than one day
82	3	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Lawrence Schaefer
13. Birthplace ?

MOTHER
14. Maiden Name Katherine Schaefer
15. Birthplace ?

16 (a) Informant Mr. George Coleman
(b) Address 4230 Stanwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6.9.44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director [illegible]
(b) Address 3305 [illegible]

19 (a) JUN 8 1944 (b) Huntington Williams, Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944, to June 1944, and that I last saw her alive on June 6 1944.

Immediate cause of death Myocardial Insufficiency — Duration 4 yrs
Due to Arteriosclerosis
Due to Rheumatic Heart
Other Conditions Angina
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Zimmerman M. D.
Address 9858 Harford Rd Date signed 6-9-44

G 17977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3330 Ravenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Ravenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lulu M Swift

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1870

8. AGE: Years 73. | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House work

11. Industry or business of home

FATHER
12. Name James H Swift
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary L. Quinlan
15. Birthplace Baltimore, Md

16 (a) Informant Miss Mary M. Swift
(b) Address 2427 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4301 Frederick Avenue

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) JUN 8 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1944, at 10:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1944 to 6-6- 1944, and that I last saw her alive on 6-6- 1944.

Immediate cause of death Cerebral Thrombosis — Duration 3 days

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN - Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed 6-8-44

C 17978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135

C 17978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 N Barre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) Maryland County
(c) City or town Baltimore Co. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 N. Barre St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Keitha Norman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Henry Norman
6 (c) If alive, give age 29 years
7. Birth date of deceased (mo., day, yr.) 1917.?
8. AGE: Years 27 | Months | Days | If less than one day ____ hr. ____ min.
9. Birthplace Clarksville Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Domestic

FATHER
12. Name William Jones
13. Birthplace Clarksville Va.?

MOTHER
14. Maiden Name Mary Yancey?
15. Birthplace Va.

16 (a) Informant Minnie Jones
(b) Address 545 W. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-44 (month) (day) (year)
(c) Cemetery or crematory
Location Henderson N. C.

18 (a) Funeral director Hattie R. Williams
(b) Address 322 N. Schroeder St. Huntington or Williams, W. Va.

JUN 8 1944 (Date received by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4, 1944 at 2:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10th 44 to June 4th 44 and that I last saw her alive on 6/1/44 1944.

Immediate cause of death Acute Miliary Tuberculosis — Duration 2 mo

Due to Tuberculer Infection — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Gunn
Address 532 N. Arlington Date signed 6/8/44

G 17979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G 17979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 Dolphin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 Dolphin St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Irene A. M. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Avon B Scott

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 16, 1892

8. AGE: Years 52 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name James Moore
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Hettie Harden
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Avon B. Scott
(b) Address 736 Dolphin St

17 (a) Burial (b) Date thereof 6-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 332 N. Schroeder St.

19 JUN 8 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1944, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1944, to 6-5 1944, and that I last saw h alive on 6/5 1944.

Immediate cause of death: Mitral Insufficiency — Duration 6 mos 2 days

Due to

Due to

Other Conditions Ethanol

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Staughen

Address 825 N. Fremont Ave Date signed 6/8/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

Registered No. G 17980

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 570 E. 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 570 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irma P. Ehelff.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30 — 1894.

8. AGE: Years	Months	Days	If less than one day
49.	8 9	7 6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Bureau of Adjustment

11. Industry or business

FATHER
12. Name William Jr. Ehelff.
13. Birthplace Churchill Va

MOTHER
14. Maiden Name Mary A. Schoen
15. Birthplace Baltimore Md

16 (a) Informant Mrs. William Ehelff.
(b) Address 570 E. 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10 - 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md

18 (a) Funeral director Manner Cook Syfan
(b) JUN 9 1944 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944, at 10-22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1941 to June 6th 1944, and that I last saw h[illegible] alive on June 6th 1944.

Immediate cause of death	Duration
Rheumatic Endocarditis	2 1/2 yrs.
Due to Rheumatic Fever	2 1/2 yrs.
Due to Cerebral Embolism	6 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Hansen M. D.
Address 1 W. Preston Date signed 6/7/44

G 17981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 83a

G 17981

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12- 2- 22
(e) Length of stay in Baltimore (yrs., mos., or days) 12 - 2 - 22

2

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Sparkill (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Agnes Convent (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Christina Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1862

8. AGE: Years	Months	Days	If less than one day
82	4	6	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name James Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Gibbons
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-44 (month) (day) (year)
(c) Cemetery or crematory Catholic Cemetery
Location Sparkill - N. Y.

18 (a) Funeral director Stewart Brown Co.
(b) Address 108 W. Preston St.

19 JUN 9 1944 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934 to June 8, 1944, and that I last saw her alive on June 8, 1944.

Immediate cause of death	Duration
Sept Cerebral Hemorrhage	1 day
Due to Arterio Sclerosis	
Due to	
Other Conditions Senile Psychosis	12 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Claffey M. D.
Address 33 W. Chelten Ave. Date signed

G 17932 BALTIMORE CITY HEALTH DEPARTMENT G 17932
CERTIFICATE OF DEATH Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Ellamont Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Ellamont Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ERNEST WILSON

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 215-01-1399

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bernadette
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 1899
8. AGE: Years 45 | Months - 1 | Days - | If less than one day hr. min.

9. Birthplace: California (Town, county, and state)
10. Usual Occupation: Welder
11. Industry or business: Harvey Stambaugh

FATHER
12. Name: unknown Wilson
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Bernadette Wilson
(b) Address: 1803 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUN 9 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 35

20. DATE OF DEATH June 7, 1944, at 1 A. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia, left upper lobe

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 7 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 17983 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Eastway (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Charles Benjamin Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-2647

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dorothy Porter Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1883

8. AGE: Years	Months	Days	If less than one day
60	11	18	? hr. ? min.

9. Birthplace Saluda Virginia (Town, County, and state)

10. Usual Occupation Vice President

11. Industry or business Standard Wholesale Phosphate Co

FATHER
12. Name William C. Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Marietta Daniels
15. Birthplace Virginia

16 (a) Informant Mrs. Chas. B. Mitchell
(b) Address Virginia.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd) (b) (Registrar)

JUN 9 - 1944 VS No. Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 7 1944 and that I last saw him alive on June 7 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Coronary Thrombosis	5 hrs & minutes
Due to Hypertensive Cardiovascular disease	3-4 yrs.
Other Conditions Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Lee Harrington Jr. M. D.
Address 332 E. University Pkwy Date signed 6/7/44

G 17984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G 17984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4321 Roseland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4321 Roseland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. PRIEST

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex m

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha F. Priest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1883

8. AGE: Years 61 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation Sales Engineer

11. Industry or business Fairbanks Morse Co.

FATHER
12. Name William H. Priest
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Webb
15. Birthplace Pa.

16 (a) Informant Mrs. Ann Weikel, Daughter
(b) Address 4 Northland Rd., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 9 - 1944 (Date rec'd by registrar) (b) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1944, at 4 30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of head

Due to

Other Conditions Mental despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-7-44 at M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury revolver

23. Signature H. L. Wallenmeyer M.D. as Medical Examiner.
Date signed 6-7-44

G 17985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 17985 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3622 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3622 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY R. MONTGOMERY

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel J. Montgomery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1857

8. AGE: Years 87 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Levin McLain
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bateman
15. Birthplace Md.

16 (a) Informant Miss Harriett Montgomery
(b) Address 3622 Park Heights Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 9 - 1944 (Date received by registrar) [illegible] Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to June 7 1944, and that I last saw h[illegible] alive on 6/7/ 1944

Immediate cause of death: Arteriosclerotic Cardiovascular Renal Disease — Duration: Several yrs.

Due to Chronic Myocarditis

Due to Cardiac Failure Original — Duration: 6 hrs.

Other Condition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 10 W. Madison St. Date signed

G 17986

G 17986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4907 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city — town limits, write RURAL and give town)
(d) Street No. 4907 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie A Ulrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ferdinand A Ulrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28 1860

8. AGE: Years 83. Months 7 Days 11 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name John F. Cook
13. Birthplace U.S.

MOTHER: 14. Maiden Name Angelina Caldwell
15. Birthplace Carroll Co Md.

16 (a) Informant Mrs. B.H. Stott
(b) Address 4907 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10/44 (Month) (year)
(c) Cemetery or crematory Loudon Pk. Cem
Location Baltimore Md.

18 (a) Funeral director C. Wells Lamorman
(b) 410 Lafayette Ave

19 (a) JUN 9 1944 (Date rec'd by registrar) Thos Hampton Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 7 1944 to JUN 7 1944 and that I last saw h E R alive on JUN 7 1944

Immediate cause of death Generalized Peritonitis

Due to after Cerebral Embolism

Due to Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration
7 days
1 mo
(9)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence XXX M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXX While at work? No (Specify type of place)
(e) Means of injury XXX

23. Signature Elliott Duke M. D.
Address 938 E. North Ave Date signed 6/9/44

VS 150

G 17987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17987 $3a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2227 N. Howard St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2227 N. Howard St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Arthur Morrison Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9-1894

8. AGE: Years	Months	Days	If less than one day
50	-	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James A. Morrison Sr

13. Birthplace Maryland

MOTHER 14. Maiden Name Emma Jenkins

15. Birthplace Va

16 (a) Informant Aletha Gray

(b) Address 2227 N Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 11-44 (month) (day) (year)

(c) Cemetery or crematory Laurel

Location Baltimore

18 (a) Funeral director Rayner Sanders

(b) Address 412 E Preston St

19 (a) (Signature of local registrar) (b) Registrar

JUN 9 - 1944

VS Rec'd Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to June 8 1944, and that I last saw h— alive on June 8 1944.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
8 days.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos A. Johnson

Address 2329 Linden Ave Date signed June 9 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G 17988 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Ruxton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Honkofsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alta
13. Birthplace Russia

MOTHER
14. Maiden Name Celia
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt Pt. Ref.
Location North Point Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

(Signature) Huntington Williams, M.D.

JUN 9 1944

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9-44 19 at 4 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 44 to June 9 19 44, and that I last saw h er alive on June 8 19 44.

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Bronchial arteriosclerosis	
Due to Colloid goitre	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H S Heude

Address 1314 - M North Ave Date signed 6/9/44

G 17989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 17989 Registered No. 1270

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town Tarentum
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 E 7th Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NATHAN FRIEDENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No. 207-09-5665

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1877

8. AGE: Years	Months	Days	If less than one day
67	3		hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Salesman

FATHER
12. Name Harris Friedenberg
13. Birthplace Russia

MOTHER
14. Maiden Name Leah Simon
15. Birthplace Russia

16 (a) Informant Mr Sol Friedenberg
(b) Address 3912 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1944 to 6/8 1944, and that I last saw him alive on 6/8 1944.

Immediate cause of death respiratory failure — Duration

Due to Uremia

Due to "renal shut down"

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/15/44

Major findings of operation:

of autopsy: prostatic hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Sherlin

Address Sinai Hospital Date signed 6/9/44

G 17990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G 17990 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution W. B. G. H. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Hatherland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband or wife~~ Rebecca A. Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1865

8. AGE: Years	Months	Days	If less than one day
79	1	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Clothing
11. Industry or business Merchant

FATHER
12. Name Louis Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Stern
15. Birthplace Germany

16 (a) Informant Mr. Louis Frank
(b) Address 4506 Hatherland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Sonnenstein & Sons
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 9 - 1944 Huntington Wilkerson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1944 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1944 to 6/7 1944, and that I last saw him alive on 6/7 1944

Immediate cause of death Terminal pneumonia — Duration Indef.

Due to Carcinoma Ascending Colon

Due to

Other Condition Secondary Anaemia (Severe)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Taylor M.D.
Address WBGA Date signed 6/7/44

C 17991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4-159

C 17991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Milford Rd Rout 7 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Booker T. Jones.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-44

8. AGE: Years	Months	Days	If less than one day
			19 hr. 30 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baby.

11. Industry or business

FATHER
12. Name Dudley Jones
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Zeora [redacted] Jackson
15. Birthplace Whitestone, Va.

16 (a) Informant Zeora Jackson Johnson
(b) Address Pikesville, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 9 1944 d by Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1944, to May 29 1944, and that I last saw h[redacted] alive on May 29 1944.

Immediate cause of death Premature

Due to

Due to

Other Conditions Atelectasis 2
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leroy W Tilt M.D.
Address University Hospital signed 5/29 1944

V1001

G 17992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 17992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Berry

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1868

8. AGE: Years 76 | Months -1 | Days -26 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant George Cottier

(b) Address 1609 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Wm. Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) (b) Registrar

JUN 9 1944

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1944, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22- 1944 to 6-5- 1944, and that I last saw h alive on 19

Immediate cause of death: Acute Pneumococcus Pneumonia Duration

Due to Hypertension Duration

Due to Hypertension Duration

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. H. Barksdale, M.D.

Address 526 N. Carey Street 6/5/44

G 17993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 43a

Registered No. [illegible]7993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Dorchester Rd.
(c) Hospital or institution:
25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baeto City
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Dorchester Rd (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Laura P Patterson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Forest Patterson
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 9/3/1884

8. AGE: Years	Months	Days	If less than one day
59	9	4	____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name William Shoe.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Emma Hagen.
15. Birthplace Maryland.

16 (a) Informant Forest Patterson
(b) Address 710 Dorchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto City.

18 (a) Funeral director Edw. S. Mac Gill & Co.
(b) Address Catonsville Md.

19 (a) JUN 9 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 1. P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1938 to June 7 1944 and that I last saw h[illegible] alive on June 6 1944.

Immediate cause of death	Duration
Cerebral Apoplexy	1 week.
Due to Arterial Hypertension	6 yrs.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury
23. Signature S. Lloyd Johnson M. D.
Date signed 6/9/44

G 1799H

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 17994 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Madison
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) last stay 3 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mary Davis 3 wks.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Charles Davis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1862
8. AGE: Years 82 | Months | Days | If less than one day hr. min.
9. Birthplace Balto County (Town, county, or state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Henry Davis
13. Birthplace Balto County

MOTHER 14. Maiden Name Katrina Hopkins
15. Birthplace Balto County

16 (a) Informant Miss Mabel Lewis
(b) Address 1721 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory West Lawn
Location Alpha Md

18 (a) Funeral director J. C. Higinbotham
(b) Address Ingott City, Md.

19 (a) (Date rec'd by registrar) (b) 1944 Thos. Higinbotham Williamsport Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/44 19 , at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-44 to 6/9/44, and that I last saw h[illegible] alive on 6/8/44

Immediate cause of death	Duration
R.L. Polar Pneumonia	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Adele Cone, M.D.
Address 113 Harlem Date signed 6/11/44

G 17995

G 17995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Carlton
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 4620 Walther Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Lula Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leonard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1888

8. AGE: Years 55 | Months 8 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Geo W. Seipell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma D. Kestler
15. Birthplace Baltimore

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 6/10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Old Georges Road

18 (a) Funeral director J. J. Bobby Sons
(b) Address 1111 E Lafayette St

19 (a) JUN 9 1944 (b) Registrar

VS 8

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/44 19... at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 19 44, to 6/7 19 44, and that I last saw h[illegible] alive on 6/7 19 44

Immediate cause of death: Intestinal Obstruction - partially Due to Internal Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Surgical 6/7/44
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Bailey M. D.

Address Fr. Sq. Hosp. Date signed 6/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 17996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G 17996 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MABLE E. DeMORE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Paul B. De More
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Apr. 12, 1889
8. AGE: Years 55 | Months 1 | Days 26 | If less than one day: hr. min.
9. Birthplace: Elberton, Ga. (Town, county, and state)
10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Robert Ray
13. Birthplace: Clarksville, Va.

MOTHER
14. Maiden Name: Ann Stevens
15. Birthplace: Ga.

16 (a) Informant: Mr. G. D. Franklin
(b) Address: Jacksonville Beach, Fal.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto. Md.
18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.
19 (a) JUN 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1944, at 9a M
21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to June 8 1944, and that I last saw h.. alive on June 8 1944.

Immediate cause of death: adeno carcinoma of uterus. — Duration: 3 Months
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: Feb. 1944
Major findings of operation: adenocarcinoma of uterus with growth to bladder.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Edith Mortimer Jr
Address 2706 St Paul St Date signed 6/9/44

G 17997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 17997 Registered No. 169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Maryave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Shorter

3 (b) If veteran, name war	3 (c) Social Security Account No.
World	213-14-3465

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Caroline Shorter
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1893

8. AGE: Years	Months	Days	If less than one day
50	6	26	hr. min.

9. Birthplace Sparks, Balto Co, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Shorter
13. Birthplace Sparks, Md.

MOTHER
14. Maiden Name Julia Bradden
15. Birthplace Sparks, Md.

16 (a) Informant Caroline Shorter
(b) Address 11 Maryave, Towson, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest Cem.
Location Towson Md Balto Co

18 (a) Funeral director Bafaw & Manjoy W. Knight
(b) Address 725 Aisquith St

19 (a) (b) Registrar

JUN 9 1944

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5- 1944, at 9:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractures skull

Due to

Other Conditions Lacerations & contusions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-5-44 at 4.55 P M.
(b) Where did injury occur? Md. & P.R.R. Towson 5-7 Cleveland
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Struck by railroad train

23. Signature Howard J. Needles M.D.
Medical Examiner.
Date signed 6-6-44

G 17998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G 17998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1613 Light St.

(c) Hospital or institution: Mercy Baltimore Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 125 E BARNEY ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Smith

3 (b) If veteran, name war	3 (c) Social Security Account No. 217-03-0792
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	WIDOWER

6 (b) Name of husband or wife LILLIAN SMITH

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB. 9. 1882

8. AGE: Years	Months	Days	If less than one day
62	3	29	hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation NIGHT WATCHMAN

11. Industry or business LINNEN THREAD CO

FATHER
12. Name NOT KNOWN
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant MR GEO. KEEFE

(b) Address 125 E BARNEY ST.

17 (a) BURIAL (b) Date thereof JUNE 12, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory GLEN HAVEN CEM.

Location GLEN BURNIE MD

18 (a) Funeral director Bernard C Hanke

(b) Address 121 E 21ST ST.

JUN 9 - 1944
(Date rec'd by registrar)

(b) Washington Williams M.D.
Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1944, at 8.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1944 to 6/8 1944 and that I last saw h[illegible] alive on 6/8 1944.

Immediate cause of death	Duration
Coronary occlusion	2 hrs
Due to Arterio sclerotic heart disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Charles R. Mac Donald M. D.

Address 1613 Light St Date signed 6-8-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

The G 17999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 17999 Registered No. 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 FLEET ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 FLEET ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN KALB

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: JULIA KALB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 8 1901

8. AGE: Years 43 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation SHIP LEADER
11. Industry or business BETH. SHIP. BUILDING CO.

FATHER
12. Name JOHN KALB
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARGARET HERRBELDE
15. Birthplace GERMANY

16 (a) Informant JULIA KALB. (WIFE)
(b) Address 3208 FLEET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 12/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

JUN 9 - 1944 (Registrar) (b) Huntington Hill Station, Md.

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JUNE 8 1944, at 8/10

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 19 44 to 6/8 19 44, and that I last saw h.i alive on 6/7 19 44

Immediate cause of death: Portal Cirrhosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Flom
Address 321 Courtland St Date signed 6/8/44

C. Flom

6 18000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 18600

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U M H. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto., Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3546 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mc Dreoy

G-01619

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-44

8. AGE: Years | Months | Days | If less than one day: 6 hr. — min.

9. Birthplace U M H. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Dale Mc Dreoy
13. Birthplace Iowa

MOTHER
14. Maiden Name Nancy Spurin
15. Birthplace Pennsylvania

16 (a) Informant History
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Body disposed of by hospital

18 (a) Funeral director
(b) Address

JUN 9 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28 1944 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1944 to 5-28 1944, and that I last saw him alive on 5-27 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Morris M.D.
Address U M H. Date signed 5-28-44 M. D.

G 18001 12 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 18001 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Jefferson St.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Wilbert Crump

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1897

8. AGE: Years: 47 | Months: 3 | Days: 23 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Crump

13. Birthplace Va.

MOTHER 14. Maiden Name Nancy Hargrove

15. Birthplace Va.

16 (a) Informant Fannie Crump

(b) Address 1627 Jefferson St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 9/44 (month) (day) (year)

(c) Cemetery or crematory

Location Suffolk Va

18 (a) Funeral director Mrs. Estella Elliott Dyer

(b) Address 479 N. Caroline St.

JUN 9 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944 at 6.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to June 8 1944 and that I last saw him alive on June 7 1944.

Immediate cause of death: (a) Acute Lobar Pneumonia

Due to: (b)

Due to: (c)

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. S. Allen

Address 120 Aug. th St. Date signed 6-8-44 M.D.

G 18002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

129

G 18002 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Towson. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O'leary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-35

8. AGE: Years 8 | Months 11 | Days 5. | If less than one day ... hr. ... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name John Cleary
13. Birthplace N.C.

MOTHER
14. Maiden Name Isabel Wagner
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10/44 (month) (day) (year)
(c) Cemetery or crematory Sharon Baptist
Location Sharon Harford Co Md

18 (a) Funeral director Degen & Porter
(b) Address Belair Md

(c) (Date) (Local registrar) (b) Huntington Williams, M.D. Registrar

JUN 9 1944

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944, at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944, to June 8 1944, and that I last saw h. alive on June 8 1944.

Immediate cause of death: Peritonitis, Primary — Duration 38 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6.8.44

Major findings of operation: Peritonitis, primary

of autopsy: Peritonitis, primary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M.D.
Address Johns Hopkins Hosp. Date signed 6-9-44

Bunch

G 18003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 18003 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 E. Preston (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Maria Brusio

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband xxxxxx late Mario Brusio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1863

8. AGE: Years 80 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Cefalu' Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Onofrio La Calce
13. Birthplace Italy

MOTHER
14. Maiden Name Grazia ?
15. Birthplace Italy

16 (a) Informant Angelina Verderame (Daughter)
(b) Address 832 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8-44 to 6-7-44, and that I last saw h alive on 6-7-44

Immediate cause of death: Generalized Arteriosclerosis — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
Address 234 S. Conkling St Date signed 6-8-44 (M. D.)

Vital

G 18004 ✓ G 18004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 926

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Calvert Sts.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernst O. Zschenderlein
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21-1897

8. AGE: Years	Months	Days	If less than one day
47	4	17	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Hugo Zschenderlein
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Schilling
15. Birthplace Germany

16 (a) Informant Mrs. Zschenderlein
(b) Address 2516 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. D. Whitfield & Son
(b) Address 801 Eutaw Place

JUN. 9 - 1944 (Date rec'd by registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7 1944, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1944 to 6/7 1944, and that I last saw h/ alive on 6/7 1944

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic endocarditis & pericarditis	
Due to Mitral Stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: Rheumatic Endo & Peri carditis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M.D.
Address St. Agnes Hosp. Date signed 6/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18005--87948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 18005

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city limits, give township)
(d) Street No. 4940 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luther Booze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1890

8. AGE: Years 53 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name George Booze
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Wood
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory Edgewood
Location Baltimore Md

18 (a) Funeral director L. B. Happ & Son
(b) Address 300 Eutaw Place

JUN 9 1944

(c) Received by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944 at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1944, to 6-8 1944, and that I last saw him alive on 6-8 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Maltese M.D.

Address B.C.H. Date signed 6/9/44

G 18006 ✓ G 18006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 W.Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 W.Mulberry St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Toogood

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Teresa
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/5/1867 1877
8. AGE: Years 67 | Months 4 5 | Days 2 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name James Toogood
13. Birthplace Canada

MOTHER
14. Maiden Name Annie Harmond
15. Birthplace N.J.

16 (a) Informant Roberta Lee (Sister in law)
(b) Address 706 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 512 N.Carrollton Ave

19 (a) JUN 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/1944 19 , at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to June 7 1944 and that I last saw h.e. alive on June 7 1944

Immediate cause of death: Coronary Thrombosis — Duration 6dys
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 75 [illegible] Date signed 6/9/44

4546945 D,118007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113

✓ G 18007 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Weber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-74

8. AGE: Years	Months	Days	If less than one day
69	10	26	hr. min.

9. Birthplace PA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Weber
13. Birthplace Germany

MOTHER 14. Maiden Name Agnes McWilliams
15. Birthplace PA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof June 9 1944 (month) (day) (year)
(c) Cemetery or crematory HARRISBURG CEM.
Location HARRISBURG PENNA.

18 (a) Funeral director Hillis Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Filed by Registrar Huntington Williams M.D.
(b) Date filed JUN 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944, at 1020 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944, to June 8 1944, and that I last saw HIM alive on June 8 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Senile emphysema + arteriosclerosis, generalized	
Due to	
Other Conditions Prophylaxis negative	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Gerson M. D.
Address J. H. H. Date signed 6-9-44

G 18008 BALTIMORE CITY HEALTH DEPARTMENT G 18008

CERTIFICATE OF DEATH 308

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Booker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Scott

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Alton Scott
(b) Address 1629 Booker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Halkett's, Va.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) JUN 9 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944 at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 1944, to June 6 1944, and that I last saw h. alive on 6/6 1944

Immediate cause of death	Duration
Rupture of A dissecting Aneurysm of Aorta	9 days?
Due to Athero Sclerosis	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ruptured Aortic Aneurysm, Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James L. Scott M. D.
Address University Hospital Date signed 6/9/44

G 18009 | BALTIMORE CITY HEALTH DEPARTMENT | ✓ G 18009 Registered No.

CERTIFICATE OF DEATH 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 E Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tatnall

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife: Levi Tatnall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1860

8. AGE: Years 83 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Lebanon Pa (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name Christian Smoke
FATHER 13. Birthplace Lebanon Pa.
MOTHER 14. Maiden Name Don't know
MOTHER 15. Birthplace Lebanon Pa

16 (a) Informant Mrs Maude Mitchell
(b) Address 438 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto County

18 (a) Funeral director A. Hoffman Evans
Address 405 N Charles St

JUN 9 - 1944

19 (a) (Date rec'd by registrar) (b) Registrar Hampden-Woodberry, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944, at 9:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1944 to June 9, 1944, and that I last saw him alive on June 5, 1944

Immediate cause of death	Duration
Cardiac decompensation	3 days
Due to Senile Hypostatic	6 mos
Due to Arteriosclerosis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 438 E. Fort Ave Date signed 6/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G 18010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Arlington Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Edward Beard

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charlena (nee Johnson)

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1874

8. AGE: Years 70 | Months 7 | Days 30 | If less than one day 29 hr. — min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Farm Laborer

11. Industry or business

FATHER
12. Name John Beard
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Johnson
15. Birthplace

16 (a) Informant Mrs. J. E. Beard
(b) Address 1113 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Gorsuch M.E. Church
Location Catonsville

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 (a) JUN 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944 at 7½ P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 1944, to June 9, 1944, and that I last saw him alive on June 8 1944.

Immediate cause of death: Hypostatic Congestion
Due to: Pneumonia — Duration: 14 yr.
Due to: Gen. Deterioration
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Alvey Edmonds M. D.
Address 312 E 25th Date signed 6-9-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5

~~18011~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C 18011

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2110 Penrose ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Penrose ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin B. Mix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene A. Mix
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 12 1881

8. AGE: Years	Months	Days	If less than one day
62	11	26	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Gas & Electric Co.

FATHER
12. Name Fred Mix.
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Irene A Mix
(b) Address 2110 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 527 Hollins St.

19 (a) JUN 10 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944 at 2. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to June 8 1944
and that I last saw him alive on June 7 1944

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic C.V.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Pound M.D.
Address 400 N. Payson Date signed 6/9/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

117a

Registered No. G 18012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Ave
(c) Hospital or institution: St. Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 S. Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Cuffley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 - 1884

8. AGE: Years	Months	Days	If less than one day
59	5	29	hr. min.

9. Birthplace Elkridge Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Charles J. Cuffley

13. Birthplace England

MOTHER 14. Maiden Name Cecelia Hockman

15. Birthplace Pa

16 (a) Informant Mrs Grace Daley

(b) Address 3310 Strickland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo. L Berger & Sons

(b) Address 1012 Hollins St

19 JUN 10 1944 (b) Registrar Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 19 44 at 355 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1944, to 6/7 1944, and that I last saw her alive on 6-7 1944.

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-31-44

Major findings of operation: Intestinal Obstruction, Marginal Ulcer.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.

Address St Agnes Hosp Date signed 6-9-44

G 18013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2244 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Cromer Sr

3 (b) If veteran, name war: 10
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Mary A. Cromer

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8th 1880

8. AGE: Years: 63 | Months: 10 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Crown Cork & Seal Co

FATHER
12. Name: Daniel Cromer
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Mary Gilmer
15. Birthplace: Va.

16 (a) Informant: Mary A. Cromer
(b) Address: 2244 Guilford Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Govans Presbyterian
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 217 St. Paul St

(c) Filed JUN 10 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7th 1944 at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1944 to 6/7 1944, and that I last saw h~~im~~er alive on 6/7/1944

	Duration
Immediate cause of death: Cerebral Hemorrhage	48 hrs.
Due to: Arteriosclerosis	c
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Thomas F. Clark
Address: 592 E 22nd Date signed: 6/9/44

WHITE

G 18014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18014

179a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 943 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 943 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Maisch

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 215-12-5100

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret A. Maisch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1894

8. AGE: Years	Months	Days	If less than one day
49	7	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bethlehem Steel--Fairfield

FATHER
12. Name Joseph A. Maisch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clara Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret A. Maisch
(b) Address 943 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

JUN 10 1944 (Date rec'd by Registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944, at 7:50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Barium Poisoning, probably Chloride
Due to
Other Conditions (none)
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-9 at 4 A M.
(b) Where did injury occur? 943 N. Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Probably accidental Probably oral poison.

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 6-9-44

VS 151

18015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 18015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 E. 33rd st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E. 33rd st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Florence B. Mitchell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Carroll S. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21st 1893

8. AGE: Years 51 | Months 4 | Days 17 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William J. Watson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret B. Smith
15. Birthplace Balto. Md.

16 (a) Informant Carroll S. Mitchell
(b) Address 1702 E. 33rd st.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

JUN 10 1944 (Date received) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8th 1944 at 1 02 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 8 1944, and that I last saw h alive on 19

	Duration
Immediate cause of death: Bronco Pneumonia	2d.
Due to: Arterio Sclerosis Hypertension	11d.
Due to: Arterio Sclerosis Hypertension	8d.
Other Conditions: Diabetes Mellitus	14y

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. F. A. Stevens M. D.
Address 818 Hartford Rd Date signed 6-8-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 18016

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Christian St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Christian (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Krouse

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Bessie V.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 24th 1864

8. AGE: Years	Months	Days	If less than one day
79	5	15	hr. min.

9. Birthplace York Pa (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laborer

FATHER 12. Name Joseph Krouse
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Bessie V. Krouse
(b) Address 2123 Christian St.

17 (a) Cremation (b) Date thereof 6/12/44 (month) (day) (year)
(~~Burial~~, cremation, ~~or removal~~)
(c) ~~Cemetery or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 121 St. Paul st

19 JUN 10 1944 (b) Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1944 at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25/44 19 to 6/9 1944 and that I last saw h. ~~m~~ alive on 6/9 19 44.

Immediate cause of death Arterio - sclerotic cardio - vascular disease — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD
Address 2030 Wilkens ave. Date signed 6/9/44 M. D.

18017 G 18017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 W. Mulberry St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 W. Mulberry St (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Montee Lanier

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Mal | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Melvina Lanier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27

8. AGE: Years 41 | Months 7 | Days 11 | If less than one day ..... hr. 90 min.

9. Birthplace Bath - N.C. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name John Lanier
13. Birthplace Bath - N.C.

MOTHER 14. Maiden Name Jane
15. Birthplace .....

16 (a) Informant Mrs. Melvina Lanier
(b) Address 1127 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10 1944 (month) (day) (year)
(c) Cemetery or crematory Washington
Location N.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) JUN 10 1944 (Date received) Hampton Mortuary, Inc

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1944 at 7.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1944 to 6-6 1944 and that I last saw him alive on 6-6 1944

Principal cause of death: Pulmonary Tuberculosis — Duration 1 yr.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature C. A. Pifer M.D.
Address 536 W. Lovelace St. Date signed 6-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G 18018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3814 Copley Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Copley Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JULIUS F. UHRMANN

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 705-09-3798

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1885

8. AGE: Years 59 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Camden, N. J. (Town, county, and state)
10. Usual Occupation Passengdr Conductor
11. Industry or business B. & O. R. R.

FATHER
12. Name Frederick Uhrmann
13. Birthplace Fallsburg, Germany

MOTHER
14. Maiden Name Bertha Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Frieda B. Harvey
(b) Address 2104 E. Ripley St., Phila., Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Washington Williams, M.D. Registrar

JUN 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to June 8 1944, and that I last saw h-- alive on June 8 1944

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to: arteriosclerosis — 9
Due to: ? — about 1 mo
Other Conditions: myocarditis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Tabb M. D.
Address 2220 Harrison Date signed Blvd. June 8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B 18019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G 18019 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Bloomingdale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Bloomingdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA L. LURSSEN

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John C. Lurssen
6 (c) If alive, give age 1944 ~~1888~~

7. Birth date of deceased (mo., day, yr.): Oct. 20, ~~1888~~ 1887

8. AGE: Years ~~56~~ 59 | Months 7 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housekeeper
11. Industry or business:

FATHER
12. Name: George Bartholomaei
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: August S. Stoffregen
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Augusta S. Siemers, Sister
(b) Address: 422 Evesham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) JUN 10 1944 (b) Address: Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1944 to June 9 1944, and that I last saw h[illegible] alive on June 8 1944.

Immediate cause of death: Chronic cardio vascular disease — Duration: 1 yr.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Ernest N. Lahm, M.D.
Address 736 Pop Gr. Rd
Date signed 6/9/44

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

C 18020

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Just Came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Woodstock
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Michal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1920

8. AGE: Years	Months	Days	If less than one day
23	7	29	hr. min.

9. Birthplace Wilkes Barre, Pa. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Stephen Michal
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Mart Matty
15. Birthplace Pennsylvania

16. (a) Informant Self
(b) Address

17 (a) Burial (b) Date thereof June 12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodstock, Cem.
Location Woodstock, Md.
18 (a) Funeral director Bernard C. Hoke
(b) Address 121 E. West St.

19 (a) (b) Registrar

JUN 10 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 6-9 1944 and that I last saw him alive on 6-9 1944.

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-1-44

Major findings of operation: Acute Appendicitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Gray M. D.

Address Mercy Hosp Date signed 6-9-44

G 18021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Milton Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Sophie Bartos

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late James Bartos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1873

8. AGE: Years 71 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation housewife at home

11. Industry or business

FATHER
12. Name John Jirsa
13. Birthplace czec

MOTHER
14. Maiden Name Rezac
15. Birthplace Czec

16 (a) Informant William Bartos - son
(b) Address 807 N. Milton Ave 6/12/44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles E. Schimunek.
[illegible] E. Madison St.,

19 (a) (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH June 8 1944, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 8 1944 and that I last saw her alive on June 7 1944

Immediate cause of death: Coronary Occlusion — Duration 6 days
Antecedent Cause Heart Disease — 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D
Address 2413 E Monument St Date signed 6/9/44

G 18022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G 18022

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 19-
(b) Street address
(c) Hospital or institution: Dr A Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Eagle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roman Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ruley Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Hampton Savoy

13. Birthplace Va

MOTHER 14. Maiden Name Malana Jones

15. Birthplace Va

16 (a) Informant Ruley Johnson

(b) Address 1840 Eagle

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/14 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Ag a. Co md

18 (a) Funeral director Isaiah T Brooks

(b) Address 1017 W Monument

19 (a) JUN 1944 (Date rec'd) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry-Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?

(d) Means of injury —

23. Signature Chester F Lubinski M.D. Medical Examiner.

Date signed 6/5/44

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

18023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156 B

G 18023 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2017 W. Baltimore
(c) Hospital or institution: —
20-B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar me Elmore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4-1929

8. AGE: Years 14 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace New Cumberland Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edgar me Elmore Sr
13. Birthplace New Market Pa

MOTHER 14. Maiden Name Estella Archer
15. Birthplace New Cumberland Pa

16 (a) Informant Edgar me Elmore
(b) Address 2017 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location New Cumberland Pa

18 (a) Funeral director F. S. Whitmore Son
(b) Address 301 E. Eutaw St

19 (Signature and title) (Registrar)

JUN 10 1944

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8/1944, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1944 to 6-8-1944, and that I last saw him alive on 6-8-1944

Immediate cause of death	Duration and date
Acute Cardiac Dilatation	1 day
Due to Pneumonia	
Due to	
Other Conditions Incomplete Diphtheria	8 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 701 Eutaw Date signed 6/9/44

18024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18024
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Milford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Milford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME Harry Warfield Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna M. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1853

8. AGE: Years	Months	Days	If less than one day
90	6	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Mnfrs. Agent
11. Industry or business Retired

FATHER
12. Name William Smith
13. Birthplace Unknown

MOTHER
14. Maiden Name Maria McKee
15. Birthplace Ireland

16 (a) Informant A. Loretta Noel
(b) Address 3108 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Harry E. Amacker
(b) Address 4204 Ridgewood Ave

19 JUN 10 1944 (Date received by Local Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9/44 19 . at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1944 to June 9 1944 and that I last saw h.m. alive on June 2 1944

Immediate cause of death Myocarditis — Duration 4 mo.
Due to Arteriosclerosis advanced — 7
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Nesbitt M. D.
Address 2220 Harrison Blvd. Date signed June 10/44

G 18025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G 18025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Bayonne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Bayonne Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ferdinand F. Fraang

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary J. Fraang
6 (c) If alive, give age 1901 years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1901

8. AGE: Years	Months	Days	If less than one day
62 ~~65~~	8	1	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation clerk - B.R.R.
11. Industry or business

FATHER
12. Name Benjamin Fraang
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Wagner
15. Birthplace Md.

16 (a) Informant Mrs. Mary J. Fraang
(b) Address 4210 Bayonne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruckel
(b) Address 5306 Harford Rd.

19 (a) JUN 10 1944 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8- 1944, at 9.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7- 1944, to 6-8- 1944, and that I last saw him alive on 6-7- 1944.

Immediate cause of death	Duration
Angina Pectoris	12 hrs.
Due to Coronary Disease	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Wilkinson, M. D.
Address 5713 Rel Air Rd. Date signed 6-8-44

VII 8

(over)

18026 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

94a G 13026

CERTIFICATE OF DEATH

1. PLACE OF DEATH DOA Mercy Hospital — Registered No. ____
CITY OF BALTIMORE: (No. ____ St., ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME James Thorpe — U. S. Veteran (specify WAR ____)

(a) Residence: No. 1716 Harlem Ave. St., ____ Ward.
(Usual place of abode) (If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Items of information should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of — Katie Thorpe

6. DATE OF BIRTH (month, day, year) — Feb 10, 1889

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
55	3	29	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. — Laborer.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) ____ — 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) — Wilson N. C.

FATHER
13. NAME — James Thorpe
14. BIRTHPLACE (city or town) (State or country) — Wilson N-C

MOTHER
15. MAIDEN NAME — Edith ? Wilson
16. BIRTHPLACE (city or town) (State or country) — N C

17. INFORMANT — Mrs Katie Thorpe
(Address) 1716 Harlem Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary C. Date June 11, 1944

19. UNDERTAKER — Thos Kelly R. Williams
(Address) 322 N Schroeder St

FILED JUN 11 1944 19 — Hartley Williams, M.D. Registrar.

V S 6

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 6/9/44, 19

22. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inspection thereon and from the evidence (Inquest, Autopsy or Inquiry)
obtained by said Inspection find that said deceased came (Inquest, Autopsy or Inquiry)
to ____ death on the day stated above.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	

Other contributory causes of importance:

Was an operation performed? ____ Date of ____
For what disease or injury? ____
Name of operation ____ Date of ____
What test confirmed diagnosis? ____ Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ____ Date of injury ____, 19____
Where did injury occur? ____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place ____
Manner of injury ____
Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____ If so, specify ____

(Signed) Hugh B. McNally M. D. Coroner
(Address) 700 Fleet St.

G 18027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G 18027

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Devil Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carro—
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 4
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Robertson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife J. C. Robertson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 21 26 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	5 7	14		1883

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Piedemus
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 1944 (month) (day) (year)
(c) Cemetery or crematory Meadowbrook
Location Westminster, Md.

18 (a) Funeral director W. Bankard & Sons
(b) Address Westminster, Md.

JAN 11 1944
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 1944, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1944 to 6/10 1944 and that I last saw her alive on 6/10 1944.

Immediate cause of death Peritonitis — Duration

Due to Ruptured appendix?

Due to

Other Conditions Diffuse
(Include pregnancy within 3 months of death)

Date of operation 6/9/44

Major findings of operation: Sub hepatic abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Traynor M.D.

Address Md. Gen. Hosp. Date signed 6/10/44 M. D.

VS 150

G 18028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 18028 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Preston Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary E Tennyson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife: No.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1881

8. AGE: Years 62 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Mr. John E. Tennyson
13. Birthplace Balto. Md.

MOTHER: 14. Maiden Name Miss Barbara Rodgers
15. Birthplace Balto. Md.

16 (a) Informant Barbara Ann Tennyson
(b) Address 2233 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12. 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location City

18 (a) Funeral director Jam. Mus. John W. Tuffel + Son
(b) Address 801 W. Fayette St.

19 (a) Rec'd by registrar (b) Thos. Boyton Williams M.D.

JUN 11 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1944 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944 to June 9 1944, and that I last saw h.r. alive on 6/9 1944

Immediate cause of death: Pulmonary edema — Duration:
Due to Arteriosclerotic heart disease.
Due to Generalized arteriosclerosis.
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy Coronary sclerosis. Pulmonary edema?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos Boyton Williams M.D.
Address Church Home + Hosp. Date signed 6/9/44 M. D.

G 18029 ✓ G 18029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Yates Beam

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1870

8. AGE: Years 74 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Hupp, Va (Town, county, and state)
10. Usual Occupation Carpenter. Ret. 20 yrs.
11. Industry or business

FATHER
12. Name Jacob Beam
13. Birthplace Hupp, Va

MOTHER
14. Maiden Name Mary Ellen Yates
15. Birthplace Hupp, Va.

16 (a) Informant Mrs. Edgar P. Gwynn
(b) Address 1631 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-44 (month) (day) (year)
(c) Cemetery or crematory Timberville. Com.
Location Broadway. Va. (Rockingham County)

18 (a) Funeral director Henry Sander & Sons. Inc.
(b) Address North Ave & Broadway

19 (a) JUN 11 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944 at 4.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 11- 1944, to June 9- 1944, and that I last saw h[illegible] alive on June 9- 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic myocarditis	2 yrs
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North av Date signed 6/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18030 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 797 W. Mulberry St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Three Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oak Crest
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Clark

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 19 | 1879

8. AGE: Years 64 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Annie Jeffers
15. Birthplace

16 (a) Informant Robert Clark
(b) Address Laurel, Md. R.F.D.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Bacon Chapel
Location Near Laurel

18 (a) Funeral director Medley & Selby
(b) Address 401 - 10th St.

19 (a) JUN 11 1944 (Date rec'd by registrar) (b) Huntington Wilkins, M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/44 19 , at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1944 to 6/9 1944 and that I last saw him alive on 6/8/44

Immediate cause of death — Duration

Bilat Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hawkcourse M. D.
Address 1131 Harlem Ave Date signed 6/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18031
T.G.P.--88377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 18031
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Beaumont

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1893

8. AGE: Years 46 ? Months 4 Days 12 If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Eugene Beaumont
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Florence Nay
15. Birthplace New Jersey

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Near Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 17 St. Paul St

JUN 11 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1944 to 6-10 1944 and that I last saw h[illegible] alive on 6-10 1944.

Immediate cause of death	Duration
Acute pneumonia due to	4 days
Due to toxicity	
Due to	
Other Conditions Meningococcic meningitis (Include pregnancy within 3 months of death)	6 days

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattma M.D.
Address B.C.H. Date signed 6/10/44

G 18032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18032 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Bartlett Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Bartlett Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna G. Ritter

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Robert F. Ritter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1906

8. AGE: Years 37 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name Charles W. Fink
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Gertrude C. Fowler
15. Birthplace Balto. Md.

16 (a) Informant Robert F. Ritter
(b) Address 637 Bartlett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JUN 17 1944 (a) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 - 1944, at 330 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944 to June 9 1944 and that I last saw [illegible] alive on June 8 1944

Immediate cause of death Cardiac Dilatation — Duration 1 Day

Due to Myocardial Insufficiency — Duration 1 Year
Arterial Hypertension
and Obesity

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 2025 E. North Ave Date signed 6/10/44

G 18033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 18033 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Angelika Theodoropoulos
3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE
4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or divorced: Widowed
6 (b) Name of husband: Athanasios Theodoropoulos
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): about 1879
8. AGE: Years: about 65 Months: Days: If less than one day hr. min.
9. Birthplace: Greece (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business: Self
FATHER 12. Name: Shiros Velisakopoulos
FATHER 13. Birthplace: Greece
MOTHER 14. Maiden Name: Vasiliki (Unknown)
MOTHER 15. Birthplace: Greece
16 (a) Informant: John Theodopoulos
16 (b) Address: 2316 N. Monroe St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md.
18 (a) Funeral director: William Cook Inc
18 (b) Address: 1217 St. Paul st.
19 (a) JUN 11 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944 at 3 40 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 8 1944 and that I last saw ~~he~~ she alive on June 8 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to Cerebrovascular & generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Brennan
Address St Joseph Hospital Date signed 6-8-44

M. D. B. 1362-5

G 18034

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18034

CERTIFICATE OF DEATH

1. PLACE OF DEATH Convent of the Good Shepherd 1937

CITY OF BALTIMORE: (No. 15 S. Mount St.) Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Sister Mary of St. Rita (Margaret McGann)

(a) Residence: No. 15 S. Mount St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) June 10, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84	84	0	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Invalid

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Co. Roscommon Ireland

FATHER

13. NAME Michael McGann

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Johanna Ryan

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Sister Mary of St. Pius
(Address) Convent of Good Shepherd

18. BURIAL, CREMATION, OR REMOVAL
Place Cathedral Date 6/12/44 19

19. UNDERTAKER J. Foley Bros
(Address) 21 S. Eutaw St.

JUN 11 1944

20. FILED Huntington Williams, M.D. Registrar.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Exact statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 10th, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1944, to June 10th, 1944

I last saw her alive on June 6th, 1944. Death is said to have occurred on the date stated above, at 1:30 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemorrhage from Stomach	Jan 8th '44
Deep seated cancer?	Jan months

Other contributory causes of importance:
Arteriosclerosis
Degenerative Changes
Senility

Name of operation — Date of —

What test confirmed diagnosis? Hand by physician Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) J. A. Ireland M. D.
(Address) 1301 E. Cathedral St. Balto

G 18035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

G 18035 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 Radnor Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State State (b) County --------
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Radnor Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Robert Garland Claypoole

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva Lloyd
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1875

8. AGE: Years	Months	Days	If less than one day
69	2	9	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cashier
11. Industry or business Maryland Race Tracks

FATHER
12. Name James Y. Claypoole
13. Birthplace Kent County, Md.

MOTHER
14. Maiden Name Mary Howison
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Robert G. Claypoole
(b) Address 304 Radnor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Baltimore, Md.
18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

JUN 11 1944
(Date received by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, at 12 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to June 10 1944 and that I last saw him alive on June 10 1944

Immediate cause of death	Duration
Cerebral Embolism	4 hrs.
Due to Chronic Endocarditis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl H. Benson, M.D. M. D.
Address 5111 York Rd Date June 11 1944

G 18036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G 18036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Druid Hill Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Martha Banks

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles Banks
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) 3 – 6 – 1888
8. AGE: Years 56 | Months 3 | Days 3 | If less than one day ____ hr. ____ min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business: House Keeping

FATHER
12. Name: Anson Wallace
13. Birthplace: Va.

MOTHER
14. Maiden Name: Mary Davis
15. Birthplace: Md.

16 (a) Informant: Charles Banks
(b) Address: 411 Druid Hill Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem
Location: Baltimore Md
18 (a) Funeral director: Wilson & Jackson
(b) Address: 916 Penna ave
19 (a) ____ (b) ____ (Date rec'd by registrar)

JUN 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th, 1944, at 9 p. m. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1944, to June 9, 1944, and that I last saw her alive on June 5, 1944.

Immediate cause of death: Secondary Cerebral Hemorrhage — Duration: 30 Minutes
Due to: Blood Pressure 220
Due to:
Other Conditions: Paralytic 4 yrs
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: D. Grant Scott M. D.
Address: 354 N. Gilmor St Date signed: 6-10-44

G 18037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G 18037 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Shuter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Shuter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Parham

3 (b) If veteran, name war

3 (c) Social Security Account No. W

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Dilia Parham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27 1892

8. AGE: Years	Months	Days	If less than one day
51	9	11	hr. min.

9. Birthplace Warfield Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Parham
13. Birthplace Va

MOTHER
14. Maiden Name Katie Mays
15. Birthplace Va

16 (a) Informant Christine Fowlkes
(b) Address 1022 McDonald St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/44 (month) (day) (year)

(c) Cemetery or crematory
Location Warfield, Va

18 (a) Funeral director Elroy Wilson
(b) Address 1006 Bloomfield Ave

19 (b) JUN 11 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8-44 19 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14, 1944 to June 8 1944, and that I last saw h— alive on June 7 1944

Immediate cause of death — Duration

Hypostatic Congestion Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Avery Gibson M. D.

Address 312 E 33rd Date signed 6-8-44

G 18038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

V G 18038 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 976 Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 976 Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Holland
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-12-0278

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/10/1915
8. AGE: Years 29 | Months | Days 1 | If less than one day hr. min.
9. Birthplace Lauderdale (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Alexander Holland
15. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Mitchell
15. Birthplace Md.

16 (a) Informant Elizabeth Holland
(b) Address 426 Spa Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/44 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Druid Ridge
18 (a) Funeral director L. B. Johnson
(b) Address Pimlico
(a) Registrar (b) Kathryn Williams, M.D.
JUN 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 3P M
21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 11 1944.
and that I last saw h[illegible] alive on June 10 1944.
Immediate cause of death: Myocarditis
Due to: Influenza
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 976 Hill Ave Date signed 6/12/44

G 18039
455577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63c

G 18039 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town Baltimore MIDDLE RIVER (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 - S. Belling Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Bare
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-6-44
8. AGE: Years | Months 5 | Days 4 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —
FATHER 12. Name Edison Bare
13. Birthplace NC
MOTHER 14. Maiden Name Vaian Wyrick
15. Birthplace NC
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Bachmans Cem.
Location Cordeff Ave.
18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave
19 (a)

JUN 12 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, at 6:15 A M
21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944, to June 10 1944, and that I last saw h.e.R alive on June 10, 1944.

Immediate cause of death: cardiac failure — Duration
Due to: Peritonitis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Rosen Kay M.D.
Address [illegible] Date signed 6/10/44

18040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 152

G 18040

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town ~~Glen~~ Phoenix
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Donnelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, ~~married, widowed, or divorced.~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 1943

8. AGE: Years — Months 11 Days — If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name James O'Brien Donnelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Marie Walsh
15. Birthplace Kansas

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Long Green, Balto. Co. Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) (b) Filed (month) (day) (year) Huntington Williams, M.D.

JUN 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11 1944, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1944 to 6-11 1944, and that I last saw him alive on 6-11 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Septicemia	
Due to Cellulitis - Rt. arm & forearm	
Other Conditions Convulsions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Hagley M. D.
Address University Hosp Date signed 6-11-44

G 18041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73d

Registered No. G 18041

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland
(c) Hospital or institution: West. Balt. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED: 648 S. Decker Ave
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Rayner Ave - Dukeland St.~~ 2485 Dallas (If rural, give location)
(e) Citizen of foreign country? ~~Yes~~ no (Yes or No)
If yes, name country Italy.

3 (a) FULL NAME Frank. Sciunti

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agatina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20 1874

8. AGE: Years	Months	Days	If less than one day
70	4	22 21	hr. min.

9. Birthplace Catania Italy (Town, county, and state)
10. Usual Occupation Baker (Retired)
11. Industry or business

FATHER
12. Name Giuseppe Scionti
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela Panebianco
15. Birthplace Italy

16 (a) Informant Joseph Scionti (Son)
(b) Address 605 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose.
Address 52 N. Morley St.

19 (Date rec'd by registrar) JUN 12 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11/44 19 44 at 4. P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/44 19 44 to 6/11 19 44 and that I last saw h/ alive on 6/11/44 19 44

Immediate cause of death Pulmonary edema

Due to

Due to Secondary Anemia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 11 Days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rocco Balducci
Address WB-G Hosp. Date signed 6/11/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G 18042 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29th and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Albemarle St (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) **FULL NAME** Baby Girl Pappagallo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	newborn

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/22/44

8. AGE: Years	Months	Days	If less than one day
		17	..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pappagallo
13. Birthplace Italy

MOTHER
14. Maiden Name Fannie Maddo
15. Birthplace Balti. Md

16 (a) Informant Fannie Pappagallo
(b) Address 213 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Monroe St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

JUN 12 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/44 19 ..., at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22/44, to 6/9/44 19..., and that I last saw her alive on 6/9/44 19....

Immediate cause of death ..... Duration
Unknown .....
Due to ....
Due to Premature .....
Other Conditions ....
(Include pregnancy within 3 months of death) .....
Major findings: .....
Of operations ....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas Clyde Walker M.D.
Address Franklin Sq. Hosp signed 6/9/44

C 18043 · ✓ C 18043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1103 Mother Gaston
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓ 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Mother Gaston
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia M Jackson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female 5. Color or race Col 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 1907
8. AGE: Years 36 | Months 9 | Days - | If less than one day hr. min.
9. Birthplace Belmont Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm Stanley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Matilda Chaney
15. Birthplace Balto Maryland

16 (a) Informant Henry E. Jackson
(b) Address 1103 Mother Gaston

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12 44 (month) (day) (year)
(c) Cemetery or crematory Osborn Memorial
Location Arbutus Md

18 (a) Funeral director Robert Miller
(b) Address 1516 McElderry St

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1944 to 6/9 1944.
and that I last saw h[illegible] alive on 6/9 1944.

Immediate cause of death Coronary Occlusion — Duration
Due to Acute Myocardial failure — 3 Months
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury
23. Signature Norman Higgins M. D.
Address 733 Madison Ave Date signed 6/9/44

G 18044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 18044 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Kresson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Kresson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. JACKSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	717-07-5932

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/5/1886

8. AGE: Years	Months	Days	If less than one day
58	0	4	hr. min.

9. Birthplace Coalesville, Pa. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business P. R. R.

FATHER
12. Name Augusta Jackson
13. Birthplace Pa.

MOTHER
14. Maiden Name Sallie Gillespie
15. Birthplace Pa.

16 (a) Informant Mrs. Barbara Jackson
(b) Address 110 N. Kresson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory Baker Cem.
Location Aberdeen, Md.

18 (a) Funeral director Henry Earring & Sons
(b) Address Aberdeen, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1944, to June 9 1944, and that I last saw [illegible] alive on June 9, 1944.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Hypertensive Cardio-vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Wolfe
Address 1331 E Hatton Date signed 6-13-44

Interpreter Williams, M.D.

G 18045 — BALTIMORE CITY HEALTH DEPARTMENT — G 18045

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6300 Eunice Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6300 Eunice Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUDE A. BOSLEY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1903

8. AGE: Years 41 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stephen R. Miller
13. Birthplace England

MOTHER
14. Maiden Name Selina Pendelton
15. Birthplace England

16 (a) Informant Mr. Robert F. Bosley
(b) Address 6300 Eunice Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS JUN 12 1944

Thurlington Williams, M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH June 9, 1944, at 11:26 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942, to June 9 1944.
and that I last saw her alive on June 8 1944.

Immediate cause of death: Coronary embolism — Duration: 1 hr.
Due to: phlebitis — 1 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Thorek M. D.
Address 101 W. Read St. Date signed 6-10-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

454851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46b

X G 18046

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Dayton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S Euclid Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bina McMillen

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Wesley McMillen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-87

8. AGE: Years 56 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace Md. (Thurmont)
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Marshall Michael
13. Birthplace Md (Thurmont)

MOTHER
14. Maiden Name Victoria May Barrick
15. Birthplace Md. (Thurmont)

16 (a) Informant Reconda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 13, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory U.B. cemetery
Location Thurmont Md

18 (a) Funeral director M. L. Creager Son
(b) Address Thurmont Md

19 (a) (b)
(Signature) Registrar

JUN 12 1944

Thurmont, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 9 1944 at 3.42 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 20 1944 to June - 9 1944, and that I last saw h on alive on June - 9 1944

Immediate cause of death Respiratory Failure — Duration

Due to Advanced Ca of stomach

Due to

Other Conditions Lowered Cardiac reserve - Coronary sclerosis
(Include pregnancy within 3 months of death)

Date of operation 5-23-44

Major findings of operation: Inoperable Ca of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rosene Kaye M. D.

Address JHH Date signed 6/10/44

G 18047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 18047 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Maples Grove Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK A SARGABLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1870

8. AGE: Years	Months	Days	If less than one day
73	8	22	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Domiciliary Clum. Ho.

FATHER
12. Name Michael Sargable
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Beckfold
15. Birthplace Germany

16 (a) Informant Mrs. Walter Singleton
(b) Address 3835 Yolanda Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Sieland
(b) Address Balto Md.

19 (a) JUN 13 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944, at 5 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 15/7
(a) Date of injury 6-11-44 at M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury fell down stairs

23. Signature W. L. Wallenmeyer M.D. Asst. Medical Examiner.
Date signed 6-14-44

VS 151

G 18048 ✓ G 18048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Wyman Park apts
(b) Street address Beach ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Beach ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederica Holland House

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Wm A. House
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 7 1863
8. AGE: Years 81 | Months — | Days 3 | If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John C. Holland
13. Birthplace Balto Md

MOTHER
14. Maiden Name Eleanor —
15. Birthplace Balto Md

16 (a) Informant Mr. Rufus K Goodenow
(b) Address 4 N Boulder Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md

18 (a) Funeral director Henry M Jenkins Sons Co
Address Mc Culloh & Orchard Sts

JUN 12 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, at 7.08 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 10 1944 and that I last saw her alive on June 9 1944.

Immediate cause of death: Cerebral hemorrhage — Duration 3 days

Due to: arterio sclerosis & hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Henry Dr. Carter
Address 6 Wyman Park 57 N Preston St Date signed 6/10/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 18049 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Chapel Gate Lane
(c) Hospital or institution: Pine Crest Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rochambeau Apartments (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Anne Mackenzie Campbell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Colin R. Campbell
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1869

8. AGE: Years 74 | Months 8 | Days 28 | If less than one day -- hr. --- min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation -------
11. Industry or business -------

FATHER
12. Name Donald Mackenzie
13. Birthplace Scotland

MOTHER
14. Maiden Name Anne Fraser
15. Birthplace Scotland

16 (a) Informant Miss Jane Campbell
(b) Address Rochambeau Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ /44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director W. W. Mears and Son
(b) Address 805 N. Calvert Street

19 [redacted] (Signature) Stevenson Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 1944 at 6.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 43 to June 10 1944 and that I last saw h. alive on 6/10 1944

Immediate cause of death: Myocardial Infarct — Duration 2 days
Due to: Arteriosclerosis
Due to:
Other Conditions: Senile Dementia — 8 Mos.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel P. Magnus M. D.
Address 3376 Fredericks Date signed 6/12/44

G 18050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G 18050 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Maunde Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Anna Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James W. Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-94

8. AGE: Years 49 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Adolph Polzin
13. Birthplace Germany

MOTHER 14. Maiden Name Marie Sobloski
15. Birthplace Poland

16 (a) Informant James W. Murphy
(b) Address 517 Maunde Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Catonsville Md

18 (a) Funeral director Philip J. Daly & Sons
(b) Address 1318 Light St.

19 (a) JUN 12 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, at 8.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1944 to 6/10 1944 and that I last saw her alive on 6/10 1944

Immediate cause of death	Duration
Carcinoma of Sigmoid	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None. Nov. 1943

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Lucey M. D.
Address Jr. Int. Hosp. Date signed 6/10/44

G 18051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18051 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) City, Maryland
(b) Street address 114 S. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Baker (Hedenger) Heddinger

3 (b) If veteran, name war: Civil

3 (c) Social Security Account No. 217-20-9625

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Emma Heddinger
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1870

8. AGE: Years	Months	Days	If less than one day
73	7	10	hr. min.

9. Birthplace Washington D.C. (town, county, and state)
10. Usual Occupation Cab Inspector
11. Industry or business

FATHER
12. Name Johan Heddinger
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary B. McFarland
15. Birthplace Washington D.C.

16 (a) Informant Francis P. Walsh
(b) Address 1714 Harford ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Frederick E. Cole
(b) Address 1201 W. Lombard St.

19 (a) (Signature of registrar) (b) Huntington Md. JUN 12 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944, at 7:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Le Fontaine M.D.
Medical Examiner.
Date signed June 10 1944

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18052

CERTIFICATE OF DEATH

92d

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2543 E. Biddle St 9 3 Ward)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Richard Zappacosta

If U. S. Veteran specify WAR .....

(a) Residence: No. 2543 E Biddle St, ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (Write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Filomena

6. DATE OF BIRTH (month, day, year) April 13 - 1894

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	1	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Dresser

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Clothing

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) ..... (State or country) Italy

FATHER

13. NAME .....

14. BIRTHPLACE (city or town) ..... (State or country)

MOTHER

15. MAIDEN NAME .....

16. BIRTHPLACE (city or town) ..... (State or country)

17. INFORMANT Filomena Zappacosta
(Address) 2543 E. Biddle St

18. BURIAL, CREMATION, OR REMOVAL
Place Bloom Redemption 6-12 19 44

19. UNDERTAKER Lemmon Buck
(Address) 1105 Harford Ave.

20. FILED ..... 19 .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 10, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 8, 1944, to June 10, 1944

I last saw him alive on June 10, 1944 Death is said to have occurred on the date stated above, at 1:30 A. M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis.	Unknown
Chronic Myocarditis	Unknown
Chronic Endocarditis	Unknown
Other contributory causes of importance: Congestive Heart Failure	1 hour

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify .....

(Signed) Richard Artigiani M. D.

(Address) 2942 East Fayette Street

V8 8

JUN 12 1944

Huntington Williams, M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G 18053
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamphnett Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Fleetwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Jean Kingsley
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Homer G.
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) 6-13-1898
8. AGE: Years 45 Months 11 Days 27 If less than one day hr. min.
9. Birthplace South Dakota (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business
FATHER 12. Name Albert F. Kelly
13. Birthplace Kansas
MOTHER 14. Maiden Name Alice Prosser
15. Birthplace
16 (a) Informant Homer G. Kingsley
(b) Address 3910 Fleetwood
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto
18 (a) Funeral director Leonard Clark
(b) Address 5305 Harford Rd
19 (a) (Date rec'd by registrar) (b) Registrar
JUN 19 1944 Hamilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1944, at M
21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to June 10 1944, and that I last saw her alive on June 10 1944.

	Duration
Immediate cause of death Carcinoma of colon	2 years
Due to	
Due to	
Other Conditions Myocarditis Secondary anemia (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. V. Harrold
Address 4706 Harford Road Date signed 6/12/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Use correct age is especially important.

D 18054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 562

G 18054 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Rueckert
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Rueckert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Bernadette Sperlein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edmund S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-1910

8. AGE: Years 34 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Wm C. Gilf

13. Birthplace

MOTHER 14. Maiden Name Emma V. Richardson

15. Birthplace Md

16 (a) Informant Edmund S. Sperlein

(b) Address 3206 Rueckert

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-13-44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto

18 (a) Funeral director Emma V. Lynch

(b) Address 3705 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 JUN 12 1944 Washington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 6/10 1944 and that I last saw her alive on 6/10 1944

Immediate cause of death Luetic Aroma Dissemenata — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tyler Holley

Address 3705 Harford Rd Date signed 6/12/44 D.

G 18055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18055 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Co. Catonsville
(If outside city or town limits, write RURAL and give township)
(d) Street No. 1016 Registertown Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. AMELIA JANE CARROLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 Dec. 1870

8. AGE: Years	Months	Days	If less than one day
73 74	5	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Bayne
13. Birthplace Md.

MOTHER
14. Maiden Name Victoria Edge
15. Birthplace Md.

16 (a) Informant Mrs. Carl Grafton
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 JUN 12 1944 (Date received by Registrar) (b) Huntington [illegible], Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 June 1944 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 April 1944 to 11 June 1944, and that I last saw h[illegible] alive on 11 June 1944

Immediate cause of death Cardiac resp. failure

Due to Malignancy site undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: None

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. L. Mengert Jr. M. D.
Address 332 E. University Pkwy. Date signed 6/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18056

Registered No. 6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Arlington Ave. (or rural route location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John V. McLean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Caroline McLean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1881

8. AGE: Years 63 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name John McLean

13. Birthplace Baltimore

MOTHER 14. Maiden Name Annie R. Kirby

15. Birthplace Baltimore

16 (a) Informant Caroline McLean

(b) Address 501 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director John D. Nolan

(b) Address 420 Fremont Ave

19 (a) (b) Registrar

JUN 12 1944 Huntington Williams, M.D

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 19 44 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 19 44 to 6/11 19 44

and that I last saw him alive on 6/11 19 44

Immediate cause of death Meningococcus Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers

Address Mt. Sinai Hosp. Date signed 6/11/44 M.D.

G 18057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18057 Registered No.

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Madison & Eutaw (or rural route number)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Thomas Martin
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	11	8		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Thomas Martin
13. Birthplace Ireland

MOTHER 14. Maiden Name Kate McAndrew
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Old Frederick Rd.

18 (a) Funeral director John A. McBain
(b) Address 3[illegible] Baltimore

19 (a) JUN 12 1944 (Date rec'd by registrar) Huntington for Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1944, at 6-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944, to 6/9 1944, and that I last saw him alive on 6/9 1944.

Immediate cause of death	Duration
Congestive Heart Failure	3 mo.
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature of Physician Thos. Norris M.D.
Address Bon Secours Hosp. Date signed 6/9/44

VS 3

G 18058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G 18058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2629 E. Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2629 E. Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Carey Korn

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frederick Korn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1886

8. AGE: Years 58 | Months 4 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Robert S.E. Herrman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Quarnegesser
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Wesley Monk
(b) Address 2629 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Newey Sons
(b) Address 2024 Orleans St.

19 (a) ... (Filled in by Registrar) (b) ...

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944, at 4:30 P. M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed June 10 1944

b 18059 — G 18059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 732 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-4178

4. Sex M

5. Color or race W C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Olive

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1878

8. AGE: Years 66 | Months 3 | Days | If less than one day hr. min.

9. Birthplace [redacted] - Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Thomas Walker
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Walker
15. Birthplace Md.

16 (a) Informant Olive Walker (W.)
(b) Address 1052 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director Chas H. Cooper
(b) Address 512 Cathedral St

19 (a) (Date received by local registrar) JUN 12 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intermediate
Cardiovascular renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 6-8-44

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18060 CERTIFICATE OF DEATH 932G 18060

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 2602 Pulaski St. 5th Ward)
Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S. If of foreign birth? ...yrs. ...mos. ...ds.

2. FULL NAME Mary Bonnie Hopkins
If U. S. Veteran specify WAR.....

(a) Residence: No. 2602 Pulaski St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. Color or Race: Colored
5. Single, Married, Widowed, or Divorced (write the word): Married

3a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mal Hopkins

6. DATE OF BIRTH (month, day, year): 1883

7. AGE: Years: 61 | Months: | Days: | If LESS than 1 day, ...hrs. or ...min.:

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc.: Housekeeper
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Md

FATHER
13. NAME: Richard Thomas
14. BIRTHPLACE (city or town) (State or country): Md

MOTHER
15. MAIDEN NAME: Agnes Threadgill
16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT: Mal Hopkins
(Address) 260 Pulaski St

18. BURIAL, CREMATION, OR REMOVAL
Place: Mt. Auburn Date: 6-12-1944

19. UNDERTAKER: Mrs. Katie R. Williams
(Address) 322 N. Belnord Ave.

20. FILED ....., 19.....
Registrar.

JUN 12 1944 Huntington Williams, M.D.

information should be carefully supplied. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): 6/11/44 19

22. I HEREBY CERTIFY, That I attended deceased from 6/7/44, 19 to 6/11/44, 19

I last saw her alive on 6/9/44, 19 Death is said to have occurred on the date stated above, at ...m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
A. Myocarditis	3 days
Other contributory causes of importance:	
Dropsy	6 days

Was an operation performed? ..... Date of .....
For what disease or injury? .....
Name of operation .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place .....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Richard Thomas M. D.
(Address) 1600 Druid Ave

18061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 18061 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Green St.
(b) Street address University H
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 McCulloh Court
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Bolden Ricks

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9 9 43

8. AGE: Years	Months	Days	If less than one day
—	09	—	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Baby.
11. Industry or business

FATHER
12. Name B. S. Ricks
13. Birthplace Ft. Hill - Clarke

MOTHER
14. Maiden Name Leola
15. Birthplace Searcy - Ark.

16 (a) Informant Mrs. Lesley Ricks
(b) Address 1206 Mc. Culloh St

17 (a) Burial (b) Date thereof 6-13-44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address [redacted]

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

JUN 12 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9 1944 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1944 to 6-9 1944, and that I last saw h. alive on 6-9 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Respiratory Collapse	
Tuberculosis	
Due to	
Other Conditions Miliary T. Bc.	
of Spleen	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: T. Bc -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Guthmann
Address University Hosp. Date signed 6/10/44 M. D.

G 18062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G 18062 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Carter 10

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 26 Months Days If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER FATHER

12. Name William Carter

13. Birthplace Farmville Va.

14. Maiden Name Jennie Burton

15. Birthplace Va.

16 (a) Informant Fannie Foulkes

(b) Address 1911 E. Chase St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)

(c) Cemetery or crematory

Location Farmville Va.

18 (a) Funeral director Mr. Robt Elliott Jr.

(b) Address 1129 N. Caroline St

19 (a) JUN 12 1944 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1944, at 11P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6/9/44 at 10:30P. M.

(b) Where did injury occur? Caroline & Eager Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury shot during altercation

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed June 10 1944

VS 151

G 18063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G 18063 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Wayne Ave
(c) Hospital or institution at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Wayne ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Katherina Hofmann Schorn

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Philip Schorn
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Dec-1-1856
8. AGE: Years 87 | Months 6 | Days 8 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Conrad Hofmann
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Kau
15. Birthplace Germany

16 (a) Informant Mrs Geo. Mason (daughter)
(b) Address 3007 Wayne ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)
(c) Cemetery or Crematory Loudon Pk
Location Baltimore
18 (a) Funeral director Howard Moran Co
(b) Address 108 W Monument
19 (a) Date received JUN 12 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941, to June 9 1944, and that I last saw h[illegible] alive on June 9 1944

Immediate cause of death: Chronic Glomerular nephritis — Duration 2 yrs
Due to: Chronic Pyelonephritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McCollum M.D. M. D.
Address 332 Fredericks Date signed 6-10-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6-46064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Carey and Baker St
(c) Hospital or institution: — D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Lacato

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1898

8. AGE: Years 45 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Spriggs
13. Birthplace Md.

MOTHER
14. Maiden Name Georgianna ?
15. Birthplace Md.

16 (a) Informant Allie LeCato
(b) Address 1521 Shields St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11/1944, at 2 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles P. Labrinski M.D.
Medical Examiner.
Date signed 6/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 18065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 18065

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Hoshen Ln
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. W. Pk. (If outside city or town limits, write RURAL and name town)
(d) Street No. 1403 Hoshen Ln (If no street give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) Full name Lillie Savoy
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband Fred Savoy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/1/71
8. AGE: Years 72 Months 7 Days 8 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Md

MOTHER
14. Maiden Name Fisher Bell
15. Birthplace Md

16 (a) Informant Ernest Marshall
(b) Address 1403 Hoshen Ln

17 (a) Burial (b) Date thereof 6/12/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) 6/12/44 (b) Harry Wilmer Brought M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/44 19 1:30 P. M

I hereby certify that death occurred on the date above stated; that I attended deceased from 6/9/44 to 6/9/44, and that I last saw him alive on 6/9/44

	Duration
Immediate cause of death Cerebral Hemorrhage	2 days
Due to Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 5 W. Mt. Rd Date signed 6/9/44

VS 150

G 18066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18066 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 N. Stockton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16/1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 N. Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Haywood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Pleasant
13. Birthplace Va.

MOTHER
14. Maiden Name Queenie Adams
15. Birthplace Va.

16 (a) Informant Joseph Adams
(b) Address 1113 N. Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13.44 (month) (day) (year)
(c) Cemetery or crematory Haverstraw N. Y.
Location N. Y.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pressman St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1944 to June 9 1944, and that I last saw her alive on June 8 1944.

Immediate cause of death	Duration
Hypertensive Heart Disease with Dropsy	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 703 W Fayette Ave Date signed 6-10-44

G 18067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18067 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4526 Schenley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4526 Schenley Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Mormann.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married.

6 (b) Name of husband or wife Lillian M. Mormann

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 15, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	27	hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Insurance Agent.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Lillian M. Mormann
(b) Address 4526 Schenley Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/44 (month) (day) (year)
(c) Cemetery or crematory Mouland Park.
Location Taylor Ave

18 (a) Funeral director Edelmeyer & Donovan
(b) Address 3615-17 Chestnut Ave

19 JUN 12 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1944 at 9.9. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to June 12 1944, and that I last saw him alive on May 30 1944.

Immediate cause of death: Acute Cardiac Dilatation

Due to Chr. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. L. Mormann

Address 4027 Falls Rd, Date signed 6/12/44 M. D.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

G 18068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 444 E. 22nd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 444 E. 22nd Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alphons J. Trageser

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife: Margaret S. Kennedy

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 13, 1868

8. AGE: Years 75 | Months 11 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired, Cabinet Maker

11. Industry or business

FATHER
12. Name John P. Trageser
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Thalheimer
15. Birthplace Germany

16 (a) Informant Mr. Charles A. Trageser (Son)
(b) Address 32 Charlcote Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) ____ (Date received by Registrar) (b) ____ Registrar

JUN 12 1944
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 th 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1939, to May 1944 and that I last saw h. im alive on May 15 1944

Immediate cause of death: Coronary thrombosis — Duration: ____

Due to: Arteriosclerosis — Duration: ____

Due to: Note: This man has been under my care for the past 4 yr's. He has been bed ridden for the past 8 yr's. He has suffered with progressive muscular atrophy for several yr's. — Duration: ____

Other Conditions: ____
(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____
(e) Means of injury ____

23. Signature H. W. Kenney

Address 1 E. Read Street Signed 6/11/44 M. D.

G 18069

G 18069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G 18069

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3429 Elmora Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 3429 Elmora Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret A Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12th 1856

8. AGE: Years	Months	Days	If less than one day
88	1	28	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name John S Baker

13. Birthplace Md

MOTHER — 14. Maiden Name Catherine Baker

15. Birthplace Md

16 (a) Informant Mrs Estelle M Hoose

(b) Address 3429 Elmora Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North & Rose Sts

18 (a) Funeral director Leo F Cook

(b) Address 1701-03 Patterson Park Ave

19 (a) (Date rec'd by Reg.) (b) Registrar

JUN 12 1944 Hamilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10-44 at 4 Ac M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jun 6 1944, and that I last saw h alive on 19

Immediate cause of death	Duration
Hypostatic Pneumonia	6 Days
Due to Chr. Myocarditis	1940
Due to Arter's - Sclerosis	1934
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J Rosner M.D.

Address 901 N Kenwood Ave Date signed 6/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18070
455340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. C 18070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W Cross (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eva Finnix

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife George
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) ? ? 06

8. AGE: Years	Months	Days	If less than one day
38			....hr. ....min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Harris
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Brumbley
(b) Address 10 of W. Monument St

19 JUN 12 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 2:17 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944, to June 7 1944, and that I last saw her alive on June 7 1944.

Immediate cause of death	Duration
Cardiac insufficiency	
Due to Hypertensive C.V. disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....
23. Signature John R. Brumbley M. D.
Address JHH Date signed 6/7

G 18071

BALTIMORE CITY HEALTH DEPARTMENT

T.G.P.--86109 CERTIFICATE OF DEATH ✓ 83a

G 18071
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo--16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~4940 Eastern Avenue~~ 415 N. Bonsal St.
(e) Citizen of foreign country? (If) (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age ~~1877~~ 1878

7. Birth date of deceased (mo., day, yr.) March 28, ~~1877~~ 1866?

8. AGE: Years	Months	Days	If less than one day
65 ~~77~~	2?	7?	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leonard Smith
13. Birthplace West Virginia

MOTHER
14. Maiden Name Julia Boone
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-1944 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Balto Co. Md.

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) Registrar (b) Huntington Williams M.D.
JUN 12 1944
VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1944, 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1944 to 6-5 1944 and that I last saw h~~e~~r alive on 6-5 1944

Immediate cause of death Cerebral Accident — Duration ?
Due to Generalized arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Mathews M.D.
Address B.E.14 Date signed 6/5/44

(OVER)

G 18072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓48a

G 18072 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6+ days

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1118 W Lafayette ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Lee White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1913

8. AGE: Years	Months	Days	If less than one day
30	6	10	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Peter White

13. Birthplace ?

MOTHER 14. Maiden Name Anne ?

15. Birthplace Virginia

16 (a) Informant Cardinal Johnson

(b) Address 1118 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Wm. Chas. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JUN 12 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/44 19..., at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944, to June 9 1944, and that I last saw her alive on June 9 1944.

Immediate cause of death: Metastatic carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature H. Gunther

Address Mercy Hosp Date signed 7/6/44

G 18073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92d

G 18073
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4504 Hamperth ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Hamperth ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Eva Gilbert

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William Gilbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1857

8. AGE: Years 86 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Adams Co. Pa
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Conrad Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Regner
15. Birthplace Germany

16 (a) Informant Mrs. Charles Reiner, Jr.
(b) Address 4504 Hamperth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave & Broadway.

19 (a) (b) Hamilton Md

JUN 12 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Valvular heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Signed June 10 1944

G 18074 G 18074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45b

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 74 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 days

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Nicholson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin C. Mott-Smith (Martin C. Mott-Smith)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Genevieve Mott Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26 1877

8. AGE: Years 66 | Months 6 | Days 15 | If less than one day: 13 hr. min.

9. Birthplace Honolulu (Town, county, and state)

10. Usual Occupation Physicist

11. Industry or business

FATHER
12. Name John Mott-Smith
13. Birthplace White Plains N.Y.

MOTHER
14. Maiden Name Doty, Ellen P
15. Birthplace Hawaii

16 (a) Informant Genevieve Mott-Smith
(b) Address 66 Nicholson St Nash D.C.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof June 12/44 (month) (day) (yr.)
(c) Cemetery or crematory London Park
Location 3201 Frederick Ave

18 (a) Funeral director John C. Whitehill Sons
(b) Address 900 Eutaw Place Baltimore, Md.

19 (a) [illegible] Registrar

JUN 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to June 9 1944, and that I last saw h[illegible] alive on June 9 1944

Immediate cause of death: Bronchopneumonia — Duration: 5 days

Due to: Carcinoma of tongue with radiation nephritis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 6-3-44

Major findings of operation: Gr[illegible]

of autopsy: Ulceration at base of tongue

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vernon F. Norwood M. D.
Address Church Home + Hospital Date signed 6-10-44

18075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 18075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1165 E Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 E Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES R. HAYES

3 (b) If veteran, name war: World War - 1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1894

8. AGE: Years	Months	Days	If less than one day
49	6	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation horse shoer
11. Industry or business

FATHER
12. Name James R Hayes
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Crowley
15. Birthplace Ireland

16 (a) Informant Mr William H Hayes
(b) Address 861 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat'l Cem.
Location 5501 Frederick Road

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins Street

JUN 12 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an examination (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: diabetes mellitus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Asst. Medical Examiner.
Date signed 6-11-44

G 18076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 18076

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2258 Brookfield Ave
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2258 Brookfield Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Esther Minsberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Manuel Minsberg
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868
8. AGE: Years 76 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Nachum Minsberg
11. Industry or business Russia Housewife

FATHER
12. Name Nachim Minsberg
13. Birthplace Russia

MOTHER
14. Maiden Name Mary -
15. Birthplace Russia

16 (a) Informant Miss Hattie Minsberg
(b) Address 2258 Brookfield Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St
19 (d) JUN 12 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 11:15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1944 to June 11 1944 and that I last saw her alive on June 11 1944

	Duration
Immediate cause of death: Cardiac failure	
Due to: Hypertensive Cardiovascular renal dis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isadore Shorofsky M.D. M. D.
Address 601 N. Howard St Date signed June 11 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18077 — Registered No. G 18077 / 96

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Boarman Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓ 15 40
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Boarman Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Mr. Roy Lester Chrest

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No. 213-10-8533

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elsie M. Chrest

6 (c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): July 9th 1897

8. AGE: Years 46 | Months 11 | Days 1 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Elevator Mechanic

11. Industry or business: General Elevator Co.

FATHER
12. Name: Wm Chrest
13. Birthplace: Westminster, Md.

MOTHER
14. Maiden Name: Eliza Rosenheimer
15. Birthplace: Harrow Pa

16 (a) Informant: Mrs. Elsie M. Chrest
(b) Address: 3800 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6 (month) | 14 (day) | 44 (year)
(c) Cemetery or crematory: Woodlawn
Location: Balto. Md.

18 (a) Funeral director: H.O. Wilson & Son
(b) Address: 2503 Edmondson Ave

19 (Date rec'd by registrar): JUN 12 1944 — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1944 at 11.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1944 to 6/10 1944, and that I last saw him alive on 6/10 1944

Immediate cause of death	Duration
Hemorrhage OB Mass	6 days
Due to: Anuresism of brain arteries	
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)

Date of operation: X
Major findings of operation: X
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: X
(b) Date of occurrence: X at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work? (Specify type of place)
(e) Means of injury: X

23. Signature: A A Hearn M.D.

Address: 4901 Gallerton Date signed: 6/11/44

G 18078 G 18078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Yale ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Yale ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Farrell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary M. Farrell

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31. 1891

8. AGE: Years 54 (53) | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Tavern Keeper

11. Industry or business

FATHER 12. Name James Farrell
13. Birthplace Ireland

MOTHER 14. Maiden Name Johanna Ryan
15. Birthplace Balto., Md

16 (a) Informant Mrs. Jas. A Farrell
(b) Address 405 Yale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13. 44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Balto., Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1422 Light St.

19. (a) (Date received) JUN 12 1944 Registrar Hunter Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1940 to 6/10 1944, and that I last saw h~~im~~er alive on 6/10 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 4709 Hurd Ave Date signed 6/12/44 M. D.

G 18079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161a

G 18079 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Ave
(c) Hospital or institution: Lt. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen Proving Ground Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Perry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/44

8. AGE: Years | Months | Days | If less than one day 10 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arthur Perry
13. Birthplace New Jersey

MOTHER 14. Maiden Name Irene Broom
15. Birthplace New Jersey

16 (a) Informant Major Arthur Berry
(b) Address Aberdeen Proving Ground

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (month) 7 (day) 44 (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 N. North Ave.

19 JUN 12 1944 (b) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 1944 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1944 to 6/10 1944 and that I last saw h[illegible] alive on 6/10 1944.

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Kaffman M.D. M. D.
Address Aberdeen Md. Date signed 6/10/44

G 18080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 18080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Eldorado Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Eldorado

3 (a) FULL NAME ALFRED CHARLES McKITTRICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1884

8. AGE: Years 59 | Months 5 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Division Chief

11. Industry or business Western Electric Co.

FATHER 12. Name Francis Robert Mc Kittrick

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace "

16 (a) Informant Alfred C. McKittrick, Jr. son

(b) Address 707 E. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Maryland

18 (a) Funeral director Wellington Cook Lee

(b) Address 1217 St. Paul Street

19 (a) ..... (Date rec'd by registrar) (b) .....

15 12 10 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, at 12 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. L. Wallenmeyer M.D. Medical Examiner.

Date signed 6-14-44

G 18081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 18081 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6225 Shipwreck Way.
(c) Hospital or institution: O'Donnell Hgts
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible] No name
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County O'Donnell Hgts
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6225 Shipwreck Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ayers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1944

8. AGE: Years | Months | Days | If less than one day 13 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Clark Ayers

13. Birthplace Roanoke Va.

MOTHER 14. Maiden Name Da Vernne Farrar

15. Birthplace Nelson Co. Va

16 (a) Informant Mrs. Wm. C. Ayers

(b) Address 6225 Shipwreck Way.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)

(c) Cemetery or crematory Lehnert Balto. Md

Location

18 (a) Funeral director John Ulrich

(b) Address 2008 Orleans

19 (a) [illegible] (b) [illegible]

[illegible] by [illegible] JUN 12 1944 Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944, to June 11 1944, and that I last saw him alive on June 10 1944.

Immediate cause of death Atelectasis — Duration

Due to

Due to Prematurity 7 3/4 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Dundalk, Md Date signed 6/11/44

G 18082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944 G Registered No. G 18082

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 W. Randall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 W. Randall St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George E McKeldin

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-10-7745

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah E McKeldin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1880

8. AGE: Years 63 | Months 9 | Days — | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Die setter

11. Industry or business Mutual Engraving Co

FATHER
12. Name James McKeldin
13. Birthplace Balto Md

MOTHER
14. Maiden Name Dora Grief
15. Birthplace Balto Md

16 (a) Informant Sarah E McKeldin
(b) Address 127 W. Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Balto City

18 (a) Funeral director Geo Lloyd Evans
(b) Address 409 N Charles St

19 (a) JUN 12 1944 (Date rec'd by Registrar) Thos J Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to June 11 1944; that I last saw [illegible] alive on June 11 1944.

Immediate cause of death: Exhaustion — Duration 3 days

Due to: Cerebral Hemorrhage — Indef.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. E. Campbell M. D.
Address 16 W Hamilton St Date signed

G 18083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 18083 Registered No. 1

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 N. Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1885

8. AGE: Years	Months	Days	If less than one day
58 59	5	29	hr. min.

9. Birthplace Richmond Virginia (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mary Jennings

(b) Address 1625 Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location A. A. County Md.

18 (a) Funeral director Mrs. Robert E. Elliott Dyk

(b) Address 1129 N. Carolina St.

19 (a) (b) Registrar

JUN 12 1944

Vs 11

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 11 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 10 1944 to JUN 10 1944 and that I last saw h/M alive on JUN 10 1944

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Probable General Cerebral Arteriosclerosis	
Due to Dentitions	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: XXXX

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence XXXX M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXXX (Specify type of place) While at work? No
(e) Means of injury

23. Signature Otto H. Duker M. D.

Address 928 E. North Ave Signed 6/12/44

G 18084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G 18084 Registered No.

Every item of information should be carefully supplied. Use typewriter or write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OTTIE HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth E.V.Harris

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) October 2, 1904

8. AGE: Years	Months	Days	If less than one day
39	8	8	....hr. ....min.

9. Birthplace Cahoun County, W. Va. (Town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business B & O RR

FATHER
12. Name Rev. L. C. Harris
13. Birthplace West Virginia

MOTHER
14. Maiden Name Belle W. Booker
15. Birthplace West Virginia

16 (a) Informant Mrs. Elizabeth Harris
(b) Address 2223 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13,1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Miller Lawrence
(b) Address 1005 W. Baltimore St.

JUN 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1944 at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of 6th cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-10-44 at 1411 M.
(b) Where did injury occur? North Ave Bridge over B&O Railroad
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
Means of injury pedestrian struck by train

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 6-11-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73d

C 18085 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Hood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nancy Grise

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-08

8. AGE: Years	Months	Days	If less than one day
35	8	10	hr. min.

9. Birthplace D.C (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Harrell
13. Birthplace D.C

MOTHER
14. Maiden Name Mamie Rocks
15. Birthplace D.C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) So. Norfolk, Va. (Burial, cremation, or removal) (b) Date thereof 6-15-44 (month) (day) (year)
(c) Cemetery or crematory So. Norfolk
Location Va.

18 (a) Funeral director Charles R. Law
(b) Address 807 Madison Ave.

(Date received by registrar) JUN 12 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944 to June 12 1944
and that I last saw deceased alive on June 12 1944

Immediate cause of death: Aplastic Anemia — Duration 2 yrs
Due to: Erythromyeloid metaplasia

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Date signed 6-12-44

G 18086

Fr. 433 wtt A G 18086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days. 24

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1626 E. Fort Ave. Balto. Md. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Angelo Frazitta

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Frazitta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1890

8. AGE: Years	Months	Days	If less than one day
53	7	19	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Barbering

FATHER — 12. Name Louis Frazzitta

13. Birthplace Italy

MOTHER — 14. Maiden Name Catherine Pulizzi

15. Birthplace Italy

16 (a) Informant Mr. Angelo Frazitta

(b) Address 1626 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13th 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md.

18 (a) Funeral director Charles F. Dill.

(b) Address 1501 E Fort Ave

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

JUN 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1944, at 9:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 9 1944, and that I last saw him alive on June 9 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Lung abscess	1 week
Due to	
Other Conditions Diabetes Mellitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Lung abscess

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Edmund Cook, Jr. M. D.

Address Mercy Hospital Date signed 6-9-44

G 18087 ✓ X G 18087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 b

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent Co.
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rachelh Moffett

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 55 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Kent Co Md
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business House Wife

FATHER
12. Name James Satterfield
13. Birthplace Kent Co

MOTHER
14. Maiden Name Kate Godwin
15. Birthplace Kent Co

16 (a) Informant Julia Mason
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14-44 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall Md

18 (a) Funeral director Edgar L. Lane
(b) Address Chestertown Md

19 (a) ..... (b) .....
Registrar

JUN 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 12 1944, and that I last saw her alive on June 12 1944

Immediate cause of death	Duration
Cerebro-Vascular accident	
Due to	
Due to	
Other Conditions Pulmonary TBa	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: none

of autopsy: Location Pyogenic quality

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature R. W. [illegible]

Address University Hosp Date signed 6/12/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18088 455173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 22 a

G 18088 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rockhall (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Perkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-28-13

8. AGE: Years 30 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Samuel Perkins
13. Birthplace ?

MOTHER 14. Maiden Name Elizabeth Harris
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Leverette m p
Location

18 (a) Funeral director Asbury Heney
(b) Address Chestertown Md

19 (a) Date filed JUN 13 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944, at 1150 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 11 1944, and that I last saw her alive on June 11 1944.

Immediate cause of death: Miliary tuberculosis — Duration

Due to: X tuberculous meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp Date signed 6-12-44

G 18089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G 18089

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 Hampden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) ~~County~~ City Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Hampden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David H. Boyer Sr

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-2745

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Lillie B. Boyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th 1874

8. AGE: Years	Months	Days	If less than one day
69	11	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Musician

FATHER
12. Name William Boyer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant David H. Boyer Jr.
(b) Address 2711 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

JUN 13 1944 (Date received by Registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1944, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1943 to June 10 1944 and that I last saw him alive on 6/10 1944

Immediate cause of death: Chronic myocarditis — Duration 2 yrs

Due to:

Due to:

Other Conditions: Myocarditis — Duration 1 wk.

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature Robert F. Chenowith M.D.
Address 1127 St Paul St Date signed 6/14/44

18090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C 18090

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2427 Barclay st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Barclay st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Erb

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife Henry Erb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1855

8. AGE: Years	Months	Days	If less than one day
88	9	2	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Isaac Khelfer
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant M. E. Erb
(b) Address Westminster Md

17 (a) Burial (b) Date thereof 6/13/44
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Silver Run
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

JUN 13 1944 (b) Huntington Williams, M.D.
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944, 9:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to June 10 1944 and that I last saw ~~him~~ her alive on June 10 1944

Immediate cause of death — Duration

Coronary occlusion

Due to Hypertension

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Erb M. D.
Address 4436 Md Date signed 6-12-44

18091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

300 Registered No. G 18091

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 W. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Amalia R. Roca (ROCA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Vincent H. Roca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/7/1894

8. AGE: Years 50 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Cuba (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name JOSE RUBIO
13. Birthplace Cuba

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Vincent H. Roca
(b) Address 226 W. Madison St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JUN 13 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1944 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/30 1944 to 6/11 1944, and that I last saw her alive on 6/11/44 1944.

Immediate cause of death: Lueticarteritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Nyman M. D.
Address Medical Arts Bldg. Date signed

G 18092 ✓ G 18092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Echodale Avenue (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lillie Bechtel

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~wife~~: Fred Bechtel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 7-3-1887
8. AGE: Years 56 | Months 11 | Days 8 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Adam Schmidt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Amelia G. Brandt
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Fred Bechtel
(b) Address: 4017 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: North Ave & Rose St

18 (a) Funeral director: Albert L. Dilly Jr.
(b) Address: 1906 N. Chester Street

19 (a) JUN 13 1944 (Date rec'd by registrar) (b) Thurlow Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1944 to 6/11 1944 and that I last saw her alive on 6/11 1944

Immediate cause of death: Apoplexy — Duration: 8 days
Due to: Hypertension
Due to:
Other Conditions: None
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Amelia E. Link M.D.
Address 2211 E. Lake Ave. Date signed 6/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 18093

74759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 11 - 15
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Hare

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife: Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1881

8. AGE: Years 62 | Months 6 | Days 5 | If less than one day: hr. min. 12

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name George Hare
13. Birthplace Penn.

MOTHER
14. Maiden Name Hannah Martin
15. Birthplace Penn.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 12 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3 1944 at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1943 to 6-5 1944 and that I last saw h[illegible]live on 6-3 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: ?
Due to: Hypertensive Cardio-Vascular disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Mathews
Address B.C.H. Date signed 6/5/44 M.D.

VS 150

1011

G 18094 — 2.O.P.-87110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 136 — Registered No. G 18094

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Freddie Ward

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 214-16-7795

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1888

8. AGE: Years	Months	Days	If less than one day
56 40		24	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Groom (horse)
11. Industry or business

FATHER
12. Name Abe Ward
13. Birthplace Maryland

MOTHER
14. Maiden Name Lula Hill
15. Birthplace Washington, D.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 12 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 13 1944 (Date rec'd by registrar) Thurlow Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 1944, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944 to 5-30 1944, and that I last saw h[illegible] alive on 5-30 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathue M.D.
Address B.O.H Date signed 6/9/44

VS 150

1012

G 18095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18095 Registered No.

YA47904

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs, 9mos., 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ? 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltc.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homeless
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1881 ?

8. AGE: Years 63? Months ? Days ? If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Unable to obtain further
11. Industry or business information

FATHER
12. Name Herbert
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory JUN 12 1944
Location UNIVERSITY MEDICAL SCHOOL
18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.
(Date received) Registrar

JUN 13 1944

VS 150

MEDICAL CERTIFICATION 44

20. DATE OF DEATH 6-2 19..., at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1939 to 6-2 1944 and that I last saw h[illegible] alive on 6-2 1944

Immediate cause of death	Duration
Cerebrovascular accident	
Due to Hypertension, chronic, of unknown duration	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mathews
Address B.C.H. Date signed 6/8/44 M D

1010

G 18096 ✓ G 18096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Barnes St.
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Barnes St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Healey Dawson ✓
3 (b) If veteran, name war None
3 (c) Social Security Account No. 213-07-0661
4 Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Married.
6 (b) Name of husband or wife Frances Dawson
6 (c) If alive, give age 30 years
7. Birth date of deceased (mo., day, yr.) Dec. 9, 1903
8. AGE: Years 40 Months 6 Days 2 If less than one day hr. min.
9. Birthplace Halifax County N.C. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.
FATHER 12. Name Ed. Dawson
13. Birthplace Nukunga.
MOTHER 14. Maiden Name Mattie Conner
15. Birthplace N. C.
16 (a) Informant Frances Dawson
(b) Address 1408 Barnes St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Robert L. Gough
(b) Address 1042 N. Carrollton
19 (a) JUN 13 1944 (b) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH June 11 1944, at 6 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1944 to 6/11 1944 and that I last saw him alive on 6/11 1944.
Immediate cause of death: Lobar Pneumonia — Duration 10 days
Due to Arterio Sclerosis — 60 days
Due to Hypertension Blood Pressure — 60 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. K. Blake
Address 1327 N. Carrollton Date signed 6/12/44

VS 8

G 18097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318 G 18097 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 Hartford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Hartford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Morris

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 217-03-6184

4 Sex: Male | 5. Color or race Col'd | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maggie Morris

6 (c) If widow, give age 49 years

7. Birth date of deceased (mo., day, yr.) April 22 1900

8. AGE: Years 44 Months 1 Days 19 | If less than one day hr. min.

9. Birthplace Norfolk Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Paul Hannagan Co.

FATHER 12. Name Johnnie Morris

13. Birthplace Unknown

MOTHER 14. Maiden Name Maggie Harvey

15. Birthplace N. C.

16 (a) Informant Maggie Morris

(b) Address 1233 Hartford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Robert L. Young

(b) Address 804 E. Caroline St.

19 (a) JUN 13 1944 (Date rec'd by Local Reg.) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1944 to June 11 1944 and that I last saw h..... alive on Jun 11 1944.

Immediate cause of death	Duration
(a) Coronary Thrombosis	1 day
Cardiac Decompensation	
Due to (b) Chronic Nephritis	
Due to (c)	
Other Conditions Generalized Anasarca	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Lafferd M. D.
Address 522 W. Baltimore Date signed 6/13/44

Please write plainly, with pen and ink, and avoid use of abbreviations. Give full name of deceased. Do not record occupation of housewife. Be sure to write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G 18098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 Registered No. G 18098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Calhoun Sts.
(c) Hospital or institution:
Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore – Towson, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Providence Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 15 min.

9. Birthplace Balto. City. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis Moore
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ida Mary Bruedenstein
15. Birthplace Towson, Md.

16 (a) Informant Ida Mary Moore.
(b) Address Towson, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) JUN 13 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8- 1944, at 9.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8- 1944 to 5-8- 1944 and that I last saw him alive on 5-8- 1944

Immediate cause of death	Duration
Monstrosity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J J Murdock M. D.
Address Date signed

VS 8

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 93 N

Registered No. G 18099

G 18099

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Winters Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joshua Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant Mrs Fannie Carroll
(b) Address 3 Roberts Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-44 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Huntington Williams Registrar

JUN 13 1944
VS 180
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944, to June 11 1944, and that I last saw h[illegible] alive on June 11 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	
C-V disease	
Due to Generalized arteriosclerosis	
Due to	
Other Conditions Gangrene of toes due to arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul L. Lukato M. D.
Address 1213 Light St. Date signed June 11 1944

G 18100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 18100 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmund B. Green
(c) Hospital or institution: University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W Lafayette
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Esie Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1943

8. AGE: Years 1 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Moses Harrison
13. Birthplace N. C.

MOTHER
14. Maiden Name Ruth Catlin
15. Birthplace Md.

16 (a) Informant Mrs Pearl Catlin
(b) Address 719 W. Lafayette Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JUN 13 1944 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1944, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3-1944 to 6-10 1944, and that I last saw him alive on 6-10-1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to T. B. (?)	
Due to	
Other Conditions Anemia Edema (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: None
of autopsy: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Dahlemann M. D.
Address University Hosp. Date signed 6-4-44

VS 150

G 18101

G.C.P.-188302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18101 61

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, give name of township or other town)
(d) Street No. 4940 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Dorsey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Dorsey
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Redding
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

JUN 13 1944 (b) Kenilworth Miller, M.D.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1944, at 12; PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31 1944 to 6/7 1944
and that I last saw him alive on 6/7 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 3 days
Due to: ASCVD
Due to:
Other Conditions: Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: W Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seymour M.D.
Address BCH Date signed 6/13

S 18102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18102 131a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 S East Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Roades

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Jack Roades

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1855

8. AGE: Years	Months	Days	If less than one day
89	4	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Charles Nelson
13. Birthplace Wilmington Del

MOTHER
14. Maiden Name Don't know
15. Birthplace

16 (a) Informant Mrs Bessie Hitt
(b) Address 10 S East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor Ave Balto Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md

JUN 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April, 1944 to June 12 1944 and that I last saw h[illegible] alive on June 11, 1944.

Immediate cause of death Chronic Nephritis

	Duration
Due to Uremia	
Cardiac Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan C. Burnham M. D.
Address 3134 E Baltimore St Date signed 6-13-44

G 18103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18103 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 77 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N PPK ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William A Klein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine Klein
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, (yr.)) July 25th 1866

8. AGE: Years	Months	Days	If less than one day
77	10	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Retired

FATHER
12. Name John Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Martoid
15. Birthplace Germany

16 (a) Informant Catherine Klein
(b) Address 817 N PPK Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

19 (a) (b) Huntington Williams Registrar

JUN 13 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jun 10 1944 and that I last saw h[illegible] alive on June 8 1944

Immediate cause of death Hypertension

Due to Cardio

Due to Vascular

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
two

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Reinke M. D.
Address 600 N Patterson Park Ave Date signed 6/14

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G 18104

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Cedardale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Cedardale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARENCE E. OWEN

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 705-09-3901

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Effie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1870

8. AGE: Years 73 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Gaithersburg, Md. (Town, county, and state)
10. Usual Occupation Retired Train Master
11. Industry or business B. & O. R. R.

FATHER
12. Name Thomas J. Owen
13. Birthplace Md.

MOTHER
14. Maiden Name Vandelia Magruder
15. Birthplace Md.

16 (a) Informant Mrs. Marion Soper
(b) Address 3504 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) (Signature of registrar) (b) Registrar

JUN 13 1944
VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11/44 19 , at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to 6/8 1944, and that I last saw him alive on 6/8 1944.

Immediate cause of death: Epitheliosis
Due to
Due to
Other Conditions
Duration: 15 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature J. Wirt Wilmer M.D.
Address 2125 Md. Ave. Date signed 6/12/44

18105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 18105 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH E. WILLIS

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1857

8. AGE: Years 86 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph H. Willis
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anna Sturges
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Florence E. Jackson
(b) Address 1914 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Huntington Williams, M.D.

19 (a) JUN 13 1944 (Local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1944, at 5:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943, to June 11 1944, and that I last saw her alive on June 10 1944.

Immediate cause of death: Uremia Cerebrum - Senility - Duration 6/12

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry D. McCarty M. D.
Address 37 W. Preston St Date signed June 13 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 18106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 N Barclay (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN LYMAN CAMP

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eva Blanche
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 29, 1875
8. AGE: Years 68 | Months 6 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business U. S. F & G. Co.

FATHER
12. Name Joseph Camp
13. Birthplace Pa.

MOTHER
14. Maiden Name Josephine Weidler
15. Birthplace Pa.

16 (a) Informant Mrs. Eva B. Camp
(b) Address 2100 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 13 1944 (b) (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 12, 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1943, to June 12 1944, and that I last saw him alive on June 10 1944.

Immediate cause of death: Coronary thrombosis — Duration: Recent

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Finlayson M. D.
Address 12 Edgar Pl. Date signed June 12/44

G 18107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 18107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3526 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Hayward Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY B. FLEMING

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-10-4888

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy L. (nee Shaull)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1880

8. AGE: Years 64 | Months 2 | Days 15 | If less than one day: hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Helwig and Leach

FATHER
12. Name John O. Fleming
13. Birthplace West Virginia

MOTHER
14. Maiden Name Ella Frazier
15. Birthplace West Virginia

16 (a) Informant Mrs. Daisy L. Fleming
(b) Address 3526 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) JUN 13 1944 [signature]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1944, at 4:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1944 to 6/10 1944, and that I last saw him alive on 6/10 1944.

Immediate cause of death: Hemorrhage of Pharynx — Duration 1 Day

Due to

Due to

Other Conditions Hardening of Arteries — Duration 2 yrs

(Include pregnancy within 3 months of death)

Date of operation X

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 4707 Harrison St. Attended 6/10 1944

G 18108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G 18108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer J. Hodges
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eleanna Hodges
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1898

8. AGE: Years 45 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Fallsville, N.C (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Rev. Joseph N. Hodges
13. Birthplace Fallsville N.C.

MOTHER
14. Maiden Name Sula Burns
15. Birthplace Fallsville, N.C.

16 (a) Informant Eleanna Hodges
(b) Address 1517 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) [illegible] (Signature of registrar) (b) Registrar

JUN 13 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1944 at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1944 to 6/9 1944 and that I last saw h alive on 6/8/1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lear M. D.

Address 113 Harlem Ave Date signed 6/12/44

18109 E 18109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Bakeberry Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LUTHER WILLIAMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4-42

8. AGE: Years 1 | Months 69 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Williams
13. Birthplace Columbia S.C.

MOTHER 14. Maiden Name Rebecca Butler
15. Birthplace Balto. Md

16 (a) Informant Robert Williams
(b) Address 1627 Bakeberry Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mrs. Winans.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) JUN 19 1944 (b) # (Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944 at 8 45 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-10-44 at 8 30 P. 15/2 M.
(b) Where did injury occur? Baker & Fremont Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
Means of injury pedestrian struck by auto

Signature H. L. Wallenmeyer M.D. and Medical Examiner.
Date signed 6-11-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RD 18110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a G 18110 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 Sarah Ann Street, 1 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Annabelle Trayham

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: David Trayham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1915

8. AGE: Years 29 | Months 3 | Days 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Perry Alcoran
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Clara Payne
15. Birthplace: Baltimore

16 (a) Informant: David Trayham
(b) Address: 638 Sarah Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 15 1944 (month) (day) (year)
(c) Cemetery or crematory: Sandy Springs
Location: Montgomery Co Md

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 322 N Schroeder St

19 (a) JUN 13 1944 (b)
Date rec'd by registrar — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-11 1944 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 1944 to 6-11 1944, and that I last saw her alive on 6-11 1944

Immediate cause of death: Cardio-respiratory failure — Duration:
Due to: Congestive heart failure
Due to: Hypertension
Other Conditions: Chronic glomerulo nephritis
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John C. Ozgliwski M. D.
Address: Mercy Hosp. Date signed 6-11-

G 18111 G 18111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131 N

TH. 88415

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ba 4940 Eastern Ave
(c) Hospital or institution: Baltimore, City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Moulton

3 (b) If veteran, name war: World War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Viola Moulton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27, 1895

8. AGE: Years 49 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Moulton
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Mae Sewell
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus, Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 E Lexington St

19 (a) [illegible] Washington Williams

JUN 13 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1944, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7 1944 to 6-11 1944, and that I last saw h[illegible] alive on 6-11 1944.

Immediate cause of death: Uremia — Duration: ?

Due to: Chronic glomerulo-nephritis — Duration: ?

Due to: — Duration:

Other Conditions: Unresolved pneumonia — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattmer M.D.
Address B.C.H. Date signed 6/14/44

G 1812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 1812

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutherland & Raymond Aves.
(c) Hospital or institution:
West Baltimore Gneral Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Kennedy Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Pullyfrone

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	

6 (b) Name of husband or wife
6 (c) If alive; give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1944

8. AGE: Years	Months	Days	If less than one day
			24 hr. min.

9. Birthplace East Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Salvatore Pullyfrone
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Mary Pendergast
(b) Address 2024 Kennedy Ave

17 (a) Burial (b) Date thereof 6 13 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M. Woodfield
(b) Address 1700 E. 22nd St

19 (a) (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 11:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944, to June 12 1944, and that I last saw h e alive on June 12 1944.

Immediate cause of death	Duration
Prematurity 36 hrs. child.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place).
(e) Means of injury

23. Signature Burke Baltimore
Address East Baltimore General Hosp. M. D.
Date signed 6/12/44

G 18113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 18113

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 LaRevere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Lalerview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Feldman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aaron Feldman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Baird Wiseltier

13. Birthplace Russia

14. Maiden Name Rifka -

15. Birthplace Russia

16 (a) Informant Miss Gertrude Feldman

(b) Address 2408 Lalerview Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6-12-44 (month) (day) (year)

(c) Cemetery or crematory Chesed Shel Emeth Cem Location Hebrew Rayal Park Lane Levina Ave

18 (a) Funeral director Jacob Levine Inc

(b) Address 1439 E. Balto St

19 JUN 13 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944, at 1.70 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936, to June 13, 1944, and that I last saw h[illegible] alive on June 1 1944

Immediate cause of death	Duration
Cardiac Failure	4 wks.
Due to Hypertensive Cardio-Vascular Disease	20 yrs.
Due to Essential Hypertension	20 yrs.
Other Conditions Fracture rt. Humerus & rt. Femur	1 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence May 13, 1944 M
(c) Where did injury occur? 214 or 8 Lalerview (City or town) (County)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped and fell to floor

23. Signature Herbert Goldstone M. D.

Address 43 Linden Av. Date signed June 13, 1944

Approved: Robert Lee Graham M.D. 9/6/44

G 18114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94N Registered No. G 18114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Dº A Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Patterson P'k Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Henry J. Ernst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary B. Ernst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-1880

8. AGE: Years	Months	Days	If less than one day
64	-	16	....hr. ....min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Henry Ernst
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hebe
15. Birthplace Maryland

16 (a) Informant Mrs. Mary B. Ernst
(b) Address 933 N. Pattinson P.K.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ /44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by Registrar) JUN 13 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1944, at 8.20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Dr. Hugh B. McNally M.D. Medical Examiner.
Date signed 6/12/44

G 18115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 13

G 18115 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 W Lanvale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN J. KENNEDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1895

8. AGE: Years 49 | Months 5+ | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name John J. Kennedy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Callahan
15. Birthplace Balto. Md.

16 (a) Informant Margaret Callahan (Kennedy)
(b) Address 56 N Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 40 (month) (day) (year)
(c) Cemetery or crematory St. Peter's Cem
Location Pulaski Ave

18 (a) Funeral director John J. Nolan
(b) Address 4201 Fremont Ave

19 (a) (b) Huntington Williams M.D. Registrar

JUN 13 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1944 at 8 50 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculosis, acute pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 6-11-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

455030 C 18116 BALTIMORE CITY HEALTH DEPARTMENT C 18116
CERTIFICATE OF DEATH 51 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin J. Linton
3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-07-9505

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Elizabeth D.
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 3-4-1883

8. AGE: Years 61 | Months 3 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace N.J. (Town, county, and state)

10. Usual Occupation Electrical Assistant

11. Industry or business

FATHER
12. Name James Linton
13. Birthplace PA

MOTHER
14. Maiden Name Hannah Wilshire
15. Birthplace PA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-1944 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) ... (b) ... (Registrar)
JUN 13 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944, at 1135 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1944, to June 11 1944, and that I last saw him alive on June 11 1944.

	Duration
Immediate cause of death: Cachexia	
Due to: Carcinoma of prostate 4yrs	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Presti M. D.
Address Date signed

276572
G 18117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 1817 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1048 Bond Street
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 184 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosee Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-27-21

8. AGE: Years	Months	Days	If less than one day
22	6	14	hr. min.

9. Birthplace N.C (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Charlie Williams
13. Birthplace N.C

MOTHER
14. Maiden Name Mary Rouse
15. Birthplace N.C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 6/13/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Farmville
Location N.C.

18 (a) Funeral director Isaiah D Greenlaw
(b) Address 1680 Montgomery Street

19 (a) (b) Huntingtown Md

JUN 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to June 11 1944 and that I last saw him alive on June 11 1944

Immediate cause of death	Duration
Pneumonia due to undetermined cause	8 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed 6-12-44

G 18118 G 18118

BALTIMORE CITY HEALTH DEPARTMENT

TN. 88459 CERTIFICATE OF DEATH 1226 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Gaither

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1877

8. AGE: Years 66 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Burnside
13. Birthplace Va.

MOTHER
14. Maiden Name Charlotte Dare
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Rockville Pike, Md.

18 (a) Funeral director Adams Funeral
(b) Address 1432 - York Ave

19 (a) (Signature of registrar) Hamilton Wilkinson, M.D.

JUN 13 1944
VS No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12-44 19 , at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 19 44 to June 12 1944. and that I last saw her alive on June 12 19 44.

Immediate cause of death: Acute Intestinal Obstruction — Duration 1wk

Due to: Post operative Adhesion — 7

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation June 11 1944

Major findings of operation Post operative adhesion & volvulus of ileum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balto City Hosp Date signed June 13 44

G 18179 — G 18179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E — Registered No. 18179

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
Street No. 209 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Hansen

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-44

8. AGE: Years	Months	Days	If less than one day
	1	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Frederick Hansen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Pauline Boerfator
15. Birthplace West Virginia

16 (a) Informant Frederick Hansen
(b) Address 209 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14-44 (month) (day) (year)
(c) Cemetery or crematory Bethlehem Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Meller
Address 1224 E. Jefferson St.

JUN 12 1944

19 (a) (Date rec'd by registrar) (b) Huntley H. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

30

20. DATE OF DEATH June 13 1944. at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1944 to 6-13 1944, and that I last saw h) M. alive on 6-12 1944

Immediate cause of death Anoxemia — Duration

Due to Congenital Heart Lesion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Congenital heart lesion, Pulmonic rotation of trunk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 6-13-44

G 18120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18120

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 PARKMONT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 PARKMONT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY J. WALSH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife LAWRENCE J. WALSH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 16 1875

8. AGE: Years	Months	Days	If less than one day
69	4	26	hr. min.

9. Birthplace PENNA. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name MICHAEL MURPHY
13. Birthplace IRELAND

MOTHER
14. Maiden Name ELIZABETH BOYLAN
15. Birthplace IRELAND

16 (a) Informant LAWRENCE WALSH (SON)
(b) Address 4420 PARKMONT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 16/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) 6-13-1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 12 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944, to June 12 1944, and that I last saw her alive on June 11 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 7 days
Due to: Ch. Hypertension
Due to: Arteriosclerosis
Ch. Myocarditis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. S. Hardesty M. D.
Address 4610 Belair Rd Date signed 6/13/44

G 18121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13-B

G 18121 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. CLINTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Theresa Weber

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife JOHN.B.WEBER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.6 1864

8. AGE: Years 80 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name LEONARD MARTEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MARY BENTON (DAUGHTER)
(b) Address 311 S.CLINTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 17/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiger INC.
(b) Address 403 S. Wolfe St.

(a) (Signature of registrar) (b) Registrar

JUN 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1944, to 6/12 1944, and that I last saw her alive on 6/12 1944.

Immediate cause of death cardiac failure — Duration

Due to cardiac

Due to TBC

Other Conditions gangrene of toe

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy TBC

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Labelle

Address Sinai Hospital Date signed 6/13/44 M.D.

G 18122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-D

G 18122 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 S.CHESTER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S.CHESTER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM J.JORDAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 17 1877

8. AGE: Years	Months	Days	If less than one day
66	5	25	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business FOR SELF

FATHER
12. Name JOHN T.JORDAN
13. Birthplace BALTO.

MOTHER
14. Maiden Name HANNAH ORTLIP
15. Birthplace BALTO.

16 (a) Informant ANNIE C.KLEHM (SISTER)
(b) Address 301 S.CHESTER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 14/44 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly and Geiler INC
(b) Address 403 S.WOLFE ST.

19 (a) (Signature of city registrar) (b) Registrar

JUN 13 1944

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JUNE 11 1944, at 7/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 19XX to June 11 19XX and that I last saw h.. alive on June 10 19XX.

Immediate cause of death	Duration
Asterixis	
Chronic Myocarditis	3 mo.
Secondary Pneumonia	
Due to Pulmonary Hemorrhage	(2) - 1 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leo D. Latz M. D.
Address 732 N.Potters Ln Date signed 6/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 18123 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S.MILTON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S.MILTON AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAROLINE GRAHAM

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: DANIEL J.GRAHAM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.17 1857

8. AGE: Years 87 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name AUGUST BARSTERT
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant KATHERINE BEWIG(NEICE)
(b) Address 305 S.HIGHLAND AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 15/44 (month) (day) (year)
(c) Cemetery or crematory MT.CARMEL CEM.
Location ODONNELL ST.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

(c) Date received by Registrar JUN 13 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 12 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 19.., to Jun 12 44, and that I last saw h.. alive on Jun 12 1944.

Immediate cause of death: Senility
Chron. Inf. Nephritis

	Duration
Due to: Arterio Sclerosis	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2336 E Balt Date signed 6/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 18124 Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. #6 Township Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward McCaffrey (McCaffrey)

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: SEPERATED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-78

8. AGE: Years 65 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation MERCHANT
11. Industry or business FOR SELF

FATHER
12. Name John McCaffrey
13. Birthplace Ireland

MOTHER
14. Maiden Name Sara Mary
15. Birthplace Ireland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 14/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Signature of registrar) (b) Christopher Welsh M.D.

JUN 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 11 1944 and that I last saw him alive on June 11 1944

Immediate cause of death Cerebral vascular accident (Thrombosis) — Duration

Due to Generalized arteriosclerosis

Due to

Other Conditions Arteriosclerotic heart disease - Meckel's diverticulum (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address J. H. H. Date June 6/11/44

G 18125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G 18125 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md. 26 70
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~3032~~ Bouldin Street 3324 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS PATRICK COTTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1890

8. AGE: Years	Months	Days	If less than one day
53	6	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Amer. Agri. Chemical Co.
11. Industry or business

FATHER
12. Name Patrick Cotter
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Bear
15. Birthplace Baltimore, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 15/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM.
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc
(b) Address 403 S. WOLFE ST.

19 (a) JUN 13 1944 (Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1944, at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 9, 1944, to June 10 1944, and that I last saw him alive on June 10, 1944

Immediate cause of death	Duration
Carcinoma, bronchogenic, left lung with metastasis to left ~~XXXX~~ axilla	Unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Aebtell
Address US Marine Hospital Baltimore, Md. Date signed 6/12/44 M.D.

G 18126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18126 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 S. Rappallo
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. Rappallo
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Hartnett

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	WIDOW

6 (b) Name of husband or wife MICHAEL HARTNETT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace VA.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace VA.

16 (a) Informant MARY ROMAN (SISTER IN LAW)
(b) Address 621 RAPPOLO ST.

17 (a) BURIAL (b) Date thereof JUNE 16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 403 S. Wolfe St.

19 (a) JUN 13 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION 25

20. DATE OF DEATH June 13 1944, at 8 A M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 13 1944

G 18127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G 18127

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga 4 ↑
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT HILL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1909

8. AGE: Years	Months	Days	If less than one day
34	11	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Monk

11. Industry or business

FATHER
12. Name Ned Hill
13. Birthplace Maryland

MOTHER
14. Maiden Name Sadie Taylor
15. Birthplace Maryland

16 (a) Informant The Deceased
(b) Address

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof June 15/44 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Crisfield Md

18 (a) Funeral director John G Bradshaw
(b) Address Crisfield Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944, at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944 to June 13, 1944 and that I last saw h. alive on June 13 1944

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Rheumatic Cardiovascular Disease	20 years
Due to	
Other Conditions Pulmonary Edema	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Davis M. D.
Address Mercy Hospital Date signed 6/13/44

C 1812[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. C 1812[illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital, Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Madison St.
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME William Katcef

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65	—	—	— hr. — min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Ruth Rosenblum
(b) Address Annapolis, Md.

17 (a) Removal (b) Date thereof June 13, 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Annapolis, Md.

18 (a) Funeral director B. E. Hopping
(b) Address West St Annapolis, Md.

(c) Date received by local registrar JUN 14 1944 (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944 at 4.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1944 to June 13 1944 and that I last saw him alive on June 13 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Edema	
Due to Congestive Heart Failure	?
Other Conditions Chronic Pyelonephritis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dawn
Address Sinai Hosp, Balto. Date signed 6/13/44 M. D.

G 18129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13d

Registered No. G 18129

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 Belle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Aloysius Connor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marie Connor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 2, 1902
8. AGE: Years 42 | Months 14 | Days 11 | If less than one day hr. min.
9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Sales man
11. Industry or business

FATHER
12. Name John P. Connor
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Catherine Agnes Meehan
15. Birthplace Pennsylvania

16 (a) Informant Wife
(b) Address 4805 Belle Ave, City

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/13/44 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D. C.

18 (a) Funeral director Wm. J. Tuckner & Sons
(b) Address North Penna. Ave.

19 JUN 14 1944 (Date rec'd by registrar) (c) Washington Wholesale Mkt. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944, at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944, to June 13 1944, and that I last saw him alive on June 13 1944.

Immediate cause of death: Subarachnoid hemorrhage — Duration
Due to: Hypertensive Cardio Vascular disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Winegatner M.D.
Address 332 E. Lanvale St. Date signed 6/13/44

18130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

Registered No. 18130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2546 Harford Ave
(c) Hospital or institution: 91

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 Harford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome D. Love

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Mary Love
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11th 1864

8. AGE: Years	Months	Days	If less than one day
80	4	2	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpentering

FATHER
12. Name Richard Love
13. Birthplace Virginia

MOTHER
14. Maiden Name Lettie Fox
15. Birthplace Unknown

16 (a) Informant Lillian Peters
(b) Address 2546 Harford Ave

17 (a) Burial (b) Date thereof 6/16/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

(c) By (Undertaker or Registrar) (b) Huntington Williams M.D. Registrar

JUN 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 1944, 1.40 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1944, to June 13 1944, and that I last saw ~~him~~ alive on June 12 1944.

Immediate cause of death	Duration
Arteriosclerosis	10 days
Due to age	
Due to Senility.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo. L. Timmerman M. D.
Address 2858 Harford Rd Date signed 6/13/44

T.B.P. 87610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13b

Registered No. G 18131

18131

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 27 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4105 Echodale Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mayme O. Talino (Mayme O. Talino)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Felame	White	Married

6 (b) Name of husband or wife Vincent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1913

8. AGE: Years	Months	Days	If less than one day
30	6	16	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER

12. Name Phillip Mannacapelli

13. Birthplace Italy

MOTHER

14. Maiden Name Lena Pusateri

15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof 6/15/44
(Burial, cremation, removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

JUN 14 1944 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1944 to 6-11 1944 and that I last saw h[illegible] alive on 6/4 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul Mattina M.D.

Address B.C.H. Date signed 6/14/44

G 8132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 18132
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilleland & Lanman Lane
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 W. Fairmount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fay Virginia Simms

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			15 hr. 15 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Simms
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Paul O. Matthews
15. Birthplace Balto Md

16 (a) Informant Hosp. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 14 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944, to June 12 1944, and that I last saw her alive on June 12 1944.

Immediate cause of death Pneumothorax 29 months.	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reuben Bellman M. D.
Address Hilleland & Lanman Lane Date signed 6/12/44

F 1013

G 18433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

CC 18433

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 11
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600½ E. 27½ st (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Earnest Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-7-44

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Fred Huff
13. Birthplace Va

MOTHER 14. Maiden Name Lethonia Hill
15. Birthplace Balto, Md

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL JUN 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 JUN 14 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1944, at 310 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944, to June 8 1944, and that I last saw him alive on June 8 1944.

Immediate cause of death: hypopyrexia — Duration

Due to: prematurely

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Robert Kaye M.D.

Address [illegible] Date signed June 13 1944

1015

G 18134 231266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 18134 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-44

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name Beatrice Gelchrist

15. Birthplace Va

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL JUN 13 1944

18 (a) Funeral director Commissioner of Health

(b) Address

JUN 14 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 44 at 2:10 P M

21. I certify that death occurred on the date above stated: that I attended deceased from May 28 '44 to June 6 19 44 and that I last saw [illegible] alive on June 6 19 44

Immediate cause of death Asphyxia Partial

Due to Diarrhea

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye

Address JHH Date signed 6-8-44

F 1014

G 18135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 18135

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sibinzis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Agatha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name ?

13. Birthplace Luth

MOTHER 14. Maiden Name ?

15. Birthplace Luth

16 (a) Informant Joseph Sibinzis

(b) Address 2125 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location Belair Md

18 (a) Funeral director Joseph Kasunak as Dir

(b) Address 602 W Lexington Bal

JUN 14 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 6/12 1944, and that I last saw him alive on 6/12 1944

Immediate cause of death Cerebral Hemorrhage — Duration 12 days

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Parker M. D.

Address 2145 W Balto Date signed

18136 Tschaksts G 18136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1772a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Greene St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Latvia

3 (a) FULL NAME Katherine Tschaksts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married - (separated)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Ilsa E ?

15. Birthplace Latvia

16 (a) Informant Leon STRELEVITZ

(b) Address 998 Hart Ave. White Plains, N.Y.

17 (a) Burial (b) Date thereof June 17-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location Cheswolde Cemetery

18 (a) Funeral director Joseph Kaminskas Sons

(b) Address 607 Washington Blvd

19 JUN 14 1944 Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9 1944 to 6-12 1944, and that I last saw h.e alive on 6-12 1944.

Immediate cause of death Pulmonary Edema — Duration

Due to Congestive Heart Failure

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Strangulated Umbilical Hernia - Ileostomy (Include pregnancy within 3 months of death)

Date of operation 6-9-44

Major findings of operation: Strangulated Umbilical Hernia 2 5 days duration

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Hagan

Address Univ. Hosp. Date signed 6/11/44 (M. D.)

G 18137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 528

G 18137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address La Fayette & John St
(c) Hospital or institution: Hospital for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 St Paul St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Shearn (Miss)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1866

8. AGE: Years	Months	Days	If less than one day
79 ?			hr. min.

9. Birthplace St Paul, Minnesota (Town, county, and state)

10. Usual Occupation Nurse (retired)

11. Industry or business

FATHER
12. Name ? Shearn
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Miss Rawlins (Friend)
(b) Address 214 E University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15 1944 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenmount
Location Baltimore Md

18 (a) Funeral director Henry W. Peterkin & Sons
(b) Address McCulloh & Dachandlers

19 (a) (Date rec'd by registrar) (b)

JUN 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 6.54 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to June 12 1944, and that I last saw her alive on June 12 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Generalized Arteriosclerosis & Arteriosclerotic Heart	
Due to disease	
Other Conditions Carcinoma Bladder?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howland Elwood Day M. D.
Address Hospital Women Md Date signed June 13 1944

548 Fulton Ave G 18138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 Registered No. G 18138

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4728 ALHAMBRA AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 4728 ALHAMBRA 9PTS (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Lake Drive + Linden Ave

3 (a) FULL NAME ABRAHAM HACKERMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOW

6 (b) Name of husband or wife REBECCA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name KALMAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MICHLA
15. Birthplace RUSSIA

16 (a) Informant NORTON HACKERMAN
(b) Address 4728 ALHAMBRA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-14-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO. + CONKLIN STS

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St.

19 (a) (b) Huntington McManus, M.D. Registrar

JUN 14 1944

VS 180

MEDICAL CERTIFICATION

45

20. DATE OF DEATH 6-12-44 19 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to June 12 1944, and that I last saw him alive on June 12 19 44.

Immediate cause of death Carcinoma prostate — Duration one year

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

Signature Morris Hackerman M. D.
Address 54 S. Fulton Ave Date signed 6-14-44

G 18139 G 18139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Elmhurst
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: 1708 Eutaw Place
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Weeks
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Vail Guest

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: Wm. W. Guest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1866

8. AGE: Years 78 | Months 1 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Haratia N. Vail
13. Birthplace New York City

MOTHER
14. Maiden Name Anna V. Metzcalf
15. Birthplace New York State

16 (a) Informant Alice K. Vail
(b) Address 104 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 15 JUN 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1944, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to June 11 1944, and that I last saw her alive on June 11 1944.

Immediate cause of death: Chronic Myocarditis — Duration: 3 yr.

Due to:

Due to: Senile Arteriosclerosis — Duration:

Other Conditions: Pulmonary Congestion, 15 hrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Kelly M. D.
Address 2504 St. Paul St. Date signed

G 18140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47d

Registered No. G 18140

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4700 Springdale Ave.

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4700 Springdale Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Gertrude DeCashmutt Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William H. Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1861

8. AGE: Years 83 | Months -- | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name Dr.

13. Birthplace Md.

MOTHER

14. Maiden Name Cleantha Sifert

15. Birthplace Md.

16 (a) Informant William H. Jackson

(b) Address 4700 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) Filed JUN 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 3 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to June 12 1944 and that I last saw h[illegible] alive on June 11 1944.

Immediate cause of death: Carcinoma of Rt Lung — Duration: 10 months

Due to: Cardiac decompensation — Duration: 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert F. Rietmann M. D.

Address 6 E. Biddle St. Date signed

AGCo. 5-11 2M3

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18141

CERTIFICATE OF DEATH ✓462

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Ardmore Way St., 24 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 13 ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME William Thomas Souder Social Security # 213-01-9387

(a) Residence: No. 5106 Ardmore Way St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Emma Christine ~~Souder~~

6. DATE OF BIRTH (month, day, year) June 24, 1870

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	11	13 19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Tool Room Keeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Mfg. Chemicals

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Catonsville, Maryland

FATHER

13. NAME Charles Souder
Balto. Co. Md.

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Helen Barth

16. BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

17. INFORMANT Mrs. Emma C. Souder
(Address) 5106 Ardmore Way

18. BURIAL, CREMATION, OR REMOVAL
Place Loudon Park Date June 16 19 44

19. UNDERTAKER Robert S. Little
(Address) 2700 Edmondson Ave.

20. FILED JUN 14 1944 19... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 13, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 12, 1944 to June 13, 1944

I last saw h[illegible] alive on June 12, 1944 death is said to have occurred on the date stated above, at 1 0 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Colon	Sept 1940
Metastases	

Other contributory causes of importance:
Hypostatic Pneumonia
Myocardial Failure

Name of operation Colostomy Date of Feb. 7/1941

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ...
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. ...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Beyerly Lenson-Lambert M.D.
(Address) 1824 Bloomingdale Road

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 18142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G 18142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Carlton St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Harry A. Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation Drinking

11. Industry or business

FATHER 12. Name Charles Sugar
13. Birthplace Germany

MOTHER 14. Maiden Name Sarah Sugar
15. Birthplace Harford Co. Md.

16 (a) Informant William T. Butler
(b) Address 209 N. Mount St.

17 (a)..... (Burial, cremation, or removal) (b) Date thereof 6 15 43 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto.

18 (a) Funeral director Walter Bishop
(b) Address 139 W. Lanvale St.

19. JUN 14 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 6-P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to true death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

.....

.....

Due to.....

.....

Other Conditions.....

.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed June 13 1944

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

~~18143~~ G 18143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1446 N. Mount
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1446 N. Mount
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Hattie M. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/43

8. AGE: Years | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Walter Wilson
13. Birthplace Va

MOTHER
14. Maiden Name Alice Lambert
15. Birthplace Va

16 (a) Informant Alice Wilson
(b) Address 1446 Mount St

17 (a) Disposition thereof Mt Auburn 6/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burial
Location Md

18 (a) Funeral director Rev. G. Kelson
(b) Address 1303 Presstman

19 (a) Date received (month) (day) (year) (b) [illegible] Md

JUN 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1944 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1944 to 6/12 1944 and that I last saw h alive on 19

Immediate cause of death: (a) Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Wilson M.D.
Address 1131 Hollins Date signed 6/13/44

G 18144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 18144 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. Saratoga Sts. Balto 2. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Sr. Mary Matthias Graham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1882

8. AGE: Years 61 | Months 6 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Brooklyn, N.Y. (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business Church

FATHER
12. Name Hugh Graham
13. Birthplace Brooklyn, N.Y.

MOTHER
14. Maiden Name Bridget O'Neill
15. Birthplace Brooklyn, N.Y.

16 (a) Informant Sr. Mary Celeste
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Agnes
Location Mt. Washington

18 (a) Funeral director H. B. Mears and Son
(b) Address 505 N. Calvert St.

19 (a) ... (b) ... (Date rec'd by registrar) JUN 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944, at 12:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1944, to June 13 1944, and that I last saw her alive on June 12 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Uremia	
Due to Diabetes Mellitis	

Other Conditions Cardiac hypertrophy stomatitis. paro titis
(Include pregnancy within 3 months of death)

Date of operation May 11, 1944

Major findings of operation: Parotitis

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature T. Ellsworth Cook, Jr. M. D.
Address Mercy Hospital Date signed June 13, 1944

18145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 d

G 18145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians:- please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Joshua Glover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Beulah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1883

8. AGE: Years 60 66 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Orangeburg, S.C. (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Joshua Glover, Sr.
13. Birthplace S.C.

MOTHER
14. Maiden Name Phyllis ?
15. Birthplace S.C.

16 (a) Informant Ora Johnson
(b) Address 1819 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto. County, Md.

18 (a) Funeral director Mrs. Ethel A. Elliott & Son
(b) Address 1129 N. Gaurdner St

19 (a) JUN 14 1944 (Date rec'd by registrar)

Registrar M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944 at 3 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Ruptured dissecting aneurysm of Aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraser M.D. (Medical Examiner)

Date signed June 13 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G 18146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Llewellyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country? Llewellyn (Yes or No)
If yes, name country

3 (a) FULL NAME Howard De Coursey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Charlotte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1883

8. AGE: Years	Months	Days	If less than one day
61	2	25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Columbus Decoursey
13. Birthplace Md.

MOTHER 14. Maiden Name Celestine Layton
15. Birthplace Md

16 (a) Informant Charlotte De Coursey
(b) Address 1712 Llewellyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Elberts Dyer
(b) Address 1129 N. Carlton St

JUN 14 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12-1944 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 1944 to 6-12-1944 and that I last saw [illegible] alive on 6-12-1944

Immediate cause of death: Myocarditis Ed — Duration 3 mos 1944
Due to: Poly Arthritis — 8/25/42
Due to: Poly. Neuritis — 5/28/42
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave Date signed 6/13/44

G 1817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 1817 Registered No. 1246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3043 Elliott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3043 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank N. Malczewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-4402

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Veronica Malczewski
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 24-1884

8. AGE: Years	Months	Days	If less than one day
59	7	18	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Industry

FATHER
12. Name Jacob Malczewski
13. Birthplace Poland

MOTHER
14. Maiden Name Josefine Kardenske
15. Birthplace Poland

16 (a) Informant Veronica Malczewski
(b) Address 3043 Elliott St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Fernwood Rd

18 (a) Funeral director Stephen Trzebowski Inc.
(b) Address 1000 S. Kenwood Ave

19 (a) (Date rec'd by registrar) JUN 14 1944 (b) Huntington Ave Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1944 to 6/12 1944, and that I last saw him alive on 6/10 1944.

Immediate cause of death	Duration
Chronic Myocarditis	18 months
Due to Chronic Hepatitis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NONE
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3018 O'Donnell St Date signed 6/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

455839 6 15148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 L

Registered No. 6 15148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Columbus Ave. — (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmore Elmer Robinson

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1895

8. AGE: Years 49 | Months | Days | If less than one day: hr. min.

9. Birthplace Va. — (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Washington Robinson
13. Birthplace Va. —

MOTHER
14. Maiden Name Alice —
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) JUN 14 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5th 1944 to June 11 1944 and that I last saw him alive on June 11 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 mo

Due to

Due to

Other Conditions

Operation (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Bartemeier M. D.
Address Johns Hopkins Hosp. Date signed 6-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1819 ✓ 166 G 1819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arlene Green

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Haley

15. Birthplace N.C.

16 (a) Informant Maybelle Bailey

(b) Address 728 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) JUN 14 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11- 1944, at 12 25 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of chest and abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6-10-44 at 11.20 P M.

(b) Where did injury occur? 225 N. Pine Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Shot

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed June 12 1944

4488378150 G 48150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. Car (b) County
(c) City or town Georgetown (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 High Market st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis James McConnell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-44

8. AGE: Years 48 | Months 4 | Days 10 | If less than one day: hr. min. 18 46

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business

FATHER 12. Name Thomas McConnell
13. Birthplace S.C.

MOTHER 14. Maiden Name Julia Loyal
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6 14 44 (month) (day) (year)

(c) Cemetery or crematory
Location Kingstree South Carolina

18 (a) Funeral director Philip Herring Sons
(b) Address 2124 Orleans St

JUN 14 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944 to June 13 1944, and that I last saw HIM alive on June 13 1944.

Immediate cause of death: Sarcoma of face — Duration: 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/21/44

Major findings of operation: Sarcoma of face

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George J. Hayes M. D.
Address J. H. H. Date signed 6/14

Williams M.D.

G 18151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 2 D

Registered No. G 18151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Walbrook Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS GAA

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-12-9810

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hannah Gaa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/19/1866

8. AGE: Years 77 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Wood Turner

11. Industry or business Dittmar & Sons

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Paul Gaa
(b) Address 836 Glen Allen Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Blvd.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 14 1944 (Date rec'd by registrar) [signature] Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 44, at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 19 44 to June 13 19 44, and that I last saw alive on June 6 19 44.

Immediate cause of death — Duration

Pulmonary Thrombosis — 2 days
Due to Acute Congestion —
Due to Chr. Valvular Heart Disease —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1520 E 33rd Date signed 6/16/44

G 18152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G 18152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 Cassilwood Rd.
(c) Hospital or institution: Eastlawn
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Bradford
(c) City or town Athens
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA A. FICE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1858

8. AGE: Years	Months	Days	If less than one day
85	7	5	hr. min.

9. Birthplace Ithaca, N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius Chamberlin
13. Birthplace Ithaca, N. Y.

MOTHER
14. Maiden Name Ma riam F. Woodburn
15. Birthplace Rome, Pa.

16 (a) Informant Mr. Glen Treslar
(b) Address 107 Casselwood Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/14/44 (month) (day) (year)
(c) Cemetery or crematory Tioga Point Cem.,
Location Athens, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 14 1944 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 14, 1944 at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to June 13 1944; and that I last saw h er alive on June 13 1944.

Immediate cause of death Carcinoma of Breast — Duration about 8 mo.
Due to — Duration
Due to Generalized. — Duration about 3 mo.
Other Conditions Abdominal Metastases
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Theodore N. Morrison M. D.
Address 11 E. Chase St Date signed 6/14/44

G 18153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 L

G 18153 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1a Lafayette & Johns St.
(c) Hospital or institution: Womens Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Popular Grove (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Irma Rose muhl

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Charles W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1868

8. AGE: Years	Months	Days	If less than one day
75	9	11	6 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Michael Hughes
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Margaret Lowther
15. Birthplace Ellicott City, Md.

16 (a) Informant Mrs. Gladys Albrecht
(b) Address 620 Poplar Grove St.

17 (a) Burial (b) Date thereof 6/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 6 14 1944 (b) [signature] M.D.
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to June 14 1944 and that I last saw her alive on June 13 1944.

Immediate cause of death Heart failure pneumonia — Duration 1 week

Due to post operative carcinoma sigmoid 2 yrs.

Due to

Other Conditions Gall stones emesuation — Duration 2

(Include pregnancy within 3 months of death)

Date of operation June 9 '44

Major findings of operation: Carcinoma sigmoid. Gall stones, distention

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank H. Hodgson Jr. M. D.
Woman's Hospital, Baltimore, Md 17.
Date signed June 14 1944.

Dr. Shamer
3300 W. North Ave
9-10 - 2-3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G 18154

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring La.
(c) Hospital or institution: Cold Spring Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Holly St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Franklin Reed.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 214-14-3317

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Marie Heise

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Dec 19th 1885

8. AGE: Years 58 | Months 5 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Real Estate

FATHER
12. Name Do not Know
13. Birthplace " " "

MOTHER
14. Maiden Name Do not Know
15. Birthplace " " "

16 (a) Informant Miss Edna Heise
(b) Address 713 N. Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 | 16 | 44 (month) | (day) | (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Thos. Wilkes & Son
(b) Address 2503 Edmondson Ave

JUN 14 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 1944 at 10.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944, to June 13, 1944, and that I last saw h[illegible] alive on June 13, 1944

Immediate cause of death	Duration
cerebral apoplexy	5 days
Due to Arteriosclerosis with Hypertension	3 yrs
Due to	
Other Conditions Pneumonia cerebral apoplexy	3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.

Address 3300 W. North Ave Date signed 6/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45563418155 BALTIMORE CITY HEALTH DEPARTMENT XV G 1855

CERTIFICATE OF DEATH

186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA (b) County
(c) City or town YORK (If outside city or town limits, write RURAL and give town)
(d) Street No. 165 Peytone Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William E Crowley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife MIRIAM
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 1-19-02

8. AGE: Years	Months	Days	If less than one day
42	4	25	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation MANF. MARTIN Bomber
11. Industry or business

FATHER
12. Name William J. Crowley
13. Birthplace Md.

MOTHER
14. Maiden Name EMMA Feldman
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ~~Burial~~ (Burial, cremation, or removal) (b) Date thereof 6-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Rose
Location ~~Wilkens Ave~~ York Pa

18 (a) Funeral director ~~Geo. Rhoads~~
(b) Address ~~1212 Pennsylvania Ave~~ York Pa

19 (a) JUN 14 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14 1944 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 10 1944 to JUNE 14 1944 and that I last saw HIM alive on JUNE 14 1944

Immediate cause of death	Duration
ACUTE MYOCARDIAL FAILURE	8 hrs
Due to FAT EMBOLISM	8 hrs
Due to FRACTURE OF NECK OF RIGHT FEMUR	4 days
Other Conditions HYPERTENSIVE CARDIOVASCULAR DISEASE	10 years

(Include pregnancy within 3 months of death)
Date of operation JUNE 12, 1944
Major findings of operation: FRACTURE OF NECK OF RIGHT FEMUR
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT (Specify which)
(b) Date of occurrence SAT. JUNE 10, 1944 at 4 P. M
(c) Where did injury occur? On Board Boat Near Basta, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? On Board Ship (Private) While at work? No (Specify type of place)
(e) Means of injury Ft. fell through open hatch

23. Signature Edward L. Bauman M. D.
Address Johns Hopkins Hosp. Date signed June 14 1944

Medical Examiner Wellenberger - Released to J. H. H.

G 18156 — BALTIMORE CITY HEALTH DEPARTMENT — G 18156

CERTIFICATE OF DEATH

Registered No. 30d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 6th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Central Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Pearl West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Landrum

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 15, 1899

8. AGE: Years 45 | Months 11 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Batson Pettigrew
13. Birthplace Va

MOTHER
14. Maiden Name Harriet ?
15. Birthplace Va

16 (a) Informant Landrum West.
(b) Address 1301 N. Central Ave

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)
(c) Cemetery or crematory
Location Lynchburg Va

18 (a) Funeral director Joseph B. Locke
(b) Address 1301 N. Central Ave Baltimore, Md.

19 (a) JUN 15 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944; at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Syphilitic aortitis and Valvulitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed June 13 1944

G 13157 ✓ G 1815?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Riggs Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Riggs Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman M. Meiser

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen G. Meiser
6 (c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1870

8. AGE: Years 74 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Jacob Meiser
13. Birthplace Germany

MOTHER
14. Maiden Name Carolyn Muth
15. Birthplace Germany

16 (a) Informant Mrs Mabel Super
(b) Address 106 S. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W Lombard St

19 (a) (Date rec'd by registrar) (b) Registrar
JUN 15 1944 Hamilton Station, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944, at 10.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944, to June 13 1944, and that I last saw h[illegible] alive on June 13 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days
Due to: Hypertension
Due to: Arterial Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Cole M. D.
Address 2145 W Belvedere Date signed

G 18158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C Registered No. G 18158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 N. Henry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conrad Cook

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie M. Cook
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 12 1852

8. AGE: Years 92 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Butcher
11. Industry or business Retired

FATHER
12. Name Ludwig Cook
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Klaussner
15. Birthplace Germany

16 (a) Informant William Cook
(b) Address 330 S. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) JUN 15 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 12 Midnight M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed chest, Compound comminuted fracture right leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-12-44 at 10:30 P. M. 20-4
(b) Where did injury occur? Frederick Avenue near Carrollton Viaduct
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by motor car

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date June 13 1944

VS 151

G 18159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 97

G 18159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Sinai Aged Home

(c) Hospital or institution: Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days): 9yrs

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County:

(c) City or town: Balto (If outside city or town limits, write RURAL, and give town)

(d) Street No.: Sinai Hosp. Home (If rural give location)

(e) Citizen of foreign country?: (Yes or No)

If yes, name country:

3 (a) FULL NAME: LOUISE LEDERER

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years: 72 Months: Days: If less than one day: hr. min.

9. Birthplace: CHECKA SLOVAKIA (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

MOTHER / FATHER

12. Name: DAVID LEDERER

13. Birthplace: Ch.

14. Maiden Name: SOPHIE —

15. Birthplace: Ch.

16 (a) Informant: HYMAN GOLDBERG

(b) Address: 1534 W. BALTO. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-16-44 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Friendship

Location:

18 (a) Funeral director: Jack Levins Inc

(b) Address: 143 E. Balto. St

19 (a) JUN 15 1944 (Date received) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1944 to June 15 1944, and that I last saw her alive on June 14 1944

Immediate cause of death: Unknown.

Duration

Due to:

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within three months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

(f) Signature: D Marks M.D.

Address: Sinai Hosp Date signed: 6/15

G 18160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46b

G 18160 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland SINAI
(b) Street address
(c) Hospital or institution: MONUMENT St · RUTLAND AVE

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 E. LEXINGTON ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Folus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife HYMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 7069 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Brenner
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Robt. M. Folus
(b) Address 3729 Columbus Ave

17 (a) 6-15-44 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem
Location Wash. Blvd.

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 S. Balto St

19 (a) JUN 15 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 1944 at 3:14 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1944 to 6/15 1944 and that I last saw h[illegible] alive on 6/15 1944

Immediate cause of death myocardial failure — Duration

Due to Carcinomatosis

Due to Probably primary in stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Altman M.D.
Address Sinai Hospital Date signed 6/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No. G 18161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 E. 25th st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 E. 25th st
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Helena Krumholtz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Geo. Krumholtz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not known
13. Birthplace Not known

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Mrs Stella Early
(b) Address 1709 E. 25th st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Henry Lutz
(b) Address 203 N. Broadway

19 (a) (b)
Date received by local registrar JUN 15 1944
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to June 13 1944, and that I last saw her alive on June 13 1944.

Immediate cause of death Myocarditis — Duration 13 days
Interstitial
Due to Arteriosclerosis — 5 yrs
High blood pressure
Due to Age -
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Zimmerman M. D.
Address 9858 Harford Date signed 6-15-44

Please write plainly; with ONE WORD in each space. Give full name of informant. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-18162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G-18162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 938 Whitelock St
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 Whitelock Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olga Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Laizer Cherney
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sarah ?
15. Birthplace: Russia

16 (a) Informant: Hyman Katz
(b) Address: 838 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Herring Run Cem
Location: Bowleys Lane

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

(b) Registrar

JUN 15 1944

VS 150

MEDICAL CERTIFICATION 2.15

20. DATE OF DEATH June 14, 1944, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to June 14, 1944, and that I last saw her alive on June 14 1944.

Immediate cause of death: Uremia — Duration: 2 mo.

Due to: Pyelonephritis — Duration: 8 mo.

Due to: Diabetes — Duration: 20 yrs.

Other Conditions: Arteriosclerotic Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Goldatoge M. D.

Address 1713 Linden Av Date signed June 15 1944

G 18163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 18163

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1033 S. Sharp St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write R. F. D. and give town)

(d) Street No. 1033 S. Sharp St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ida Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1901

8. AGE: Years 42 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Andrew Jones

13. Birthplace Md

MOTHER 14. Maiden Name Mary Watkins

15. Birthplace Md.

16 (a) Informant Robert Walker

(b) Address 1033 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1000 Bloom Ave Baltimore, Md

19 (a) (b)

JUN 15 1944

Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1944 6 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 6/12 1944 and that I last saw h alive on 6/12 1944

Immediate cause of death Cerebral Apoplexy, Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Frankel M. D.

Address 1122 Lee Date signed 6/14/44

18164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

Registered No. G 18164

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED 2532 Gold Spring Lane.
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Raymond Woodland Ct.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia.

3 (a) FULL NAME Nathan Rose.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bessie Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Eudah Rose
13. Birthplace Russia

MOTHER
14. Maiden Name Lefa -
15. Birthplace Russia

16 (a) Informant Bessie Rose
(b) Address 2532 Gold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jacob Levin Son
(b) Address 1739 E. Balto St

19 (a) JUN 15 1944 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1944 at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1944 to 6/14 1944 and that I last saw he was alive on 6/14 1944

Immediate cause of death Bronchopneumonia — Duration 10 Days

Due to Arteriosclerotic cardiovascular disease.

Due to

Other Conditions Heart Block 3:1.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Taylor M. D.
Address WBGN Date signed 6/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 18165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3326 ELMLEY AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3326 ELMLEY AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES B.RAU

3 (b) If veteran, name war 1 ST.W.W.

3 (c) Social Security Account No. 214 01 4098

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LILLIAN E.RAU

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT.7 1895

8. AGE: Years 48 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation PIPE FITTER

11. Industry or business STANDARD OIL CO.

FATHER
12. Name CONRAD RAU
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA SCHAUER
15. Birthplace GERMANY

16 (a) Informant LILLIAN E.RAU (WIFE)
(b) Address 3326 ELMLEY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 17/44 (month) (day) (year)
(c) Cemetery or crematory PARK WOOD
Location TAYLOR AVE.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 SARGLEE ST.

19 (a) JUN 15 1944 (Date received) (b) Registrar

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JUNE 13 1944, at 7/30M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to June 13 1944, and that I last saw h.sw alive on June 13 1944.

Immediate cause of death: Carcinoma of right lung. — Duration: 3 Months

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 6-5-44 Biopsy

Major findings of autopsy: Fragments of necl. Carcinoma of Lung.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elbert L. Mortimer Jr. M. D.

Address 2706 St Paul Date signed 6/15/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write abbreviations. Physicians: please write the causes of death clearly and legibly. Be especially important.

C 18166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 C

Registered No. C 18166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lehigh
(b) Street address 632 S. LEIGH ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 S. LEIGH ST. (Or rural route location)
(e) Citizen of foreign country? Lehigh (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GROSSMAN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 215 05 1860

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: JENNIE GROSSMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 18 1880

8. AGE: Years 64 | Months 4 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CABNET MAKER
11. Industry or business LEVIN & ZIUTH

FATHER
12. Name PETER GROSSMAN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ANNA GRAU
15. Birthplace BALTO. MD.

16 (a) Informant JENNIE GROSSMAN (WIFE)
(b) Address 632 S. IEIGH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 17/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC
Address 403 S. WOLFE ST.

19 (b) JUN 15 1944 (Date rec'd by registrar) [illegible] M.D.

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JUNE 14 1944, at 1/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to June 1944.
and that I last saw h[illegible] alive on 6/14 1944.

Immediate cause of death	Duration
(a) Cardio Sclerosis	4 yrs.
Due to (b) Arterio Sclerosis	2
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 6/15/44

S. M. Greenberg
4613 Belair Ave

G 18167 ✓ G 18167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Powell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Powell Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Willam Henry Hands

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	W

6 (b) Name of husband or wife 1.- Sarah J. Hote 2.- Mary Otto nee Richard.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10th, 1855

8. AGE: Years	Months	Days	If less than one day
89		4	hr. min.

9. Birthplace Anne Arundal Co. (Town, county, and state)
10. Usual Occupation Railroad engineer (retired)
11. Industry or business Railroad

FATHER
12. Name John N. Hands
13. Birthplace Anne Arundal Co.

MOTHER
14. Maiden Name Emma Cookman Carroll
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. Harry G. Sieling
(b) Address 4404 Powell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland
18 (a) Funeral director Rasgan Funeral Home
(b) Address 7401 Belair Road
19 (a) (Date rec'd by registrar) (b)

JUN 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14- 1944, at 1.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944, to 6-14- 1944, and that I last saw him alive on April 13 1944.

Immediate cause of death	Duration
Glasso-labial paralysis	14 days
Due to Arterio-sclerosis	
(genefal atheroma of the	
Due to arteries.)	Many yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson, M.D.
A. L. Wilkinson.
Address 5713 Belair Rd. Date signed 6-15-44

G 18168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 18168

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 128 S. Broadway

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 128 S. Broadway (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary V. Beers

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8-1885

8. AGE: Years 58 | Months 9 | Days 7 5 | If less than one day hr. min.

9. Birthplace Baltr. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Daniel J. McCarthy

FATHER 13. Birthplace Preston, Md.

MOTHER 14. Maiden Name Kate Stapleton

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Cath. Beers

(b) Address 128 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-44 (month) (day) (year)

(c) Cemetery or crematory Most Holy Red. Cath. Cem. Location Old Frederick Rd.

18 (a) Funeral director John A. Hoar

(b) Address 500 E. Balto St.

19 (a) (Date received by registrar) (b) Registrar

VS JUN 15 1944 Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13, 1940 to June 13, 1944, and that I last saw h-e- alive on June 10, 1944

Immediate cause of death: Coronary Thrombosis — Duration 1 day

Due to Arteriosclerosis, hyper. Tension (arterial) — 4 yrs.

Due to Nephritis - chronic interstitial — 4 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene L. Lansaone M. D.

Address 514 Drury Lane Date signed 6/13/44

18169 C 18169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13b

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Garner Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Houston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1. 1894

8. AGE: Years 50 | Months 0 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Work for Self

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Fannie Furgeson
(b) Address 600 West Lee Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16. 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 409 N Mount Street

JUN 15 1944 (Registrar) (b) Huntington, Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944, at 2:15 P. M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculosis Pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Wallenwein M.D. Medical Examiner.
Date signed June 14, 1944.

Please write plainly, with unfading ink. Every question must be answered, or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1864 Registered No. C 18170

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N Car oline St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1105 Ensor St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Russo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 Months Days If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Anthony Balsamo

13. Birthplace Italy

MOTHER 14. Maiden Name Mary ?

15. Birthplace Italy

16 (a) Informant Mary Russo

(b) Address 1105 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-44 (month) (day) (year)

(c) Cemetery or crematory Stoley Redeemer

Location Baltimore

18 (a) Funeral director Rita Wunderfeld

(b) Address 917 Greenmount Ave

19 JUN 15 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-13 1944, at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28 1944, to 6-13 1944, and that I last saw her alive on 6-13 1944.

Immediate cause of death: Acute myocardial failure — Duration 16 da.

Due to: Arteriosclerosis

Due to:

Other Conditions: Comminuted fracture, right elbow

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1

(a) Accident, suicide, or homicide

(b) Date of occurrence May 28, 1944 at 3P M

(c) Where did injury occur? 1105 Ensor (City or town) (County) Stoet (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify) While at work No

(e) Means of injury: fell down front steps & pavement

23. Signature: Stanley B. Klyanowski

Address St. Joseph's Hospital Date signed 6-13-44 (M D)

VS 150

approved by Howard J. Nuckels, M.D.

18171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. C 18171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 n. Register street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 n Register St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Drucilla Eleanora Steinert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6th 1873

8. AGE: Years	Months	Days	If less than one day
71	9	7	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Steinert
13. Birthplace Md

MOTHER 14. Maiden Name Anna Pedrick
15. Birthplace Md

16 (a) Informant Mr. Becker
(b) Address 1812 N. Register St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17th 1944 (month) (day) (year)
(c) Cemetery or crematory Baltolawn
Location East North Ave Ext

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Date received (month) (day) (year) (b) Registrar

JUN 15 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944 at 9 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Lee death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to hypertensive cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slaton M.D. Medical Examiner.
Date signed June 13 1944

G 18172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178

Registered No. G 18172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 44 Franklin Square
(c) Hospital or institution: Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4803 Sunbrook Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret Noonan 32120

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John P. Noonan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28th 1923

8. AGE: Years 21 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Barry Rider
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Rider
15. Birthplace Md

16 (a) Informant Mr. J. P. Noonan
(b) Address 4803 Sunbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Leo S. Brook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) JUN 15 1944 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13/44 19 , at 2.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6/44 19 to 6/13/44 19 , and that I last saw her alive on 6/13/44 19

Immediate cause of death: Acute Pancreatitis — Duration

Due to:

Due to:

Other Conditions: 1) Bilateral Non-Suppurative Pneumonia 2) Uremia 3) Furunculosis
(Include pregnancy within 3 months of death)

Major findings: Of operations: Steatonecrosis

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Gluck M. D.
Address Franklin Sq. Hosp. Date signed 6/13/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18173

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 Normal Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Normal Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Schriver
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-1444

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Margaret Schriver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1883

8. AGE: Years 60 | Months 11 | Days 30 | If less than one day hr. min.

9. Birthplace Lansdowne - Md. (Town, county, and state)
10. Usual Occupation carpenter
11. Industry or business

FATHER 12. Name George Schriver
13. Birthplace Md.
MOTHER 14. Maiden Name Julia Wolf
15. Birthplace Md.

16 (a) Informant Mrs. Margaret Schriver
(b) Address 1726 Normal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leopold J. Ruck
(b) Address 5305 Harford Rd. Baltimore, Md.

19 (a) JUN 15 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1944 at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939, to 6-14 1944.
that I last saw him alive on 6-14 1944.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to arterio sclerosis	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Elbert H. Mortimer Jr. M. D.
Address 2706 St Paul Date signed 6-14-44

G 18174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G 18174

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5307 N. Charles St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5307 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country ----------

3 (a) FULL NAME James Keelty

3 (b) If veteran, name war ----------
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ###### wife Nora Sheridan
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 75	---	---	--- hr. ---- min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Builder
11. Industry or business Builder

FATHER
12. Name James Keelty
13. Birthplace Ireland

MOTHER
14. Maiden Name Honora O'Neill
15. Birthplace Ireland

16 (a) Informant Mrs. Nora Keelty
(b) Address 5307 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)
(c) Cemetery ###### New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares & Son
(b) Address 805 N. Calvert St.

JUN 15 1944 (Date received by Registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 1 07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1921, to June 15 1944, and that I last saw ~~X~~ M alive on June 15 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension cardio-vascular disease	
Due to Cerebral hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kenneth D. Lyon M. D.
Address 222 Medical Arts Bldg Date signed 6.15.44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. 18175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6102 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6102 Park Heights Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: SIMON J. BLOCK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rae H. Block
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1871.

8. AGE: Years 72 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Investment Broker
11. Industry or business

FATHER
12. Name Solomon S. Block,
13. Birthplace Alexandria, Va.

MOTHER
14. Maiden Name Theresa Brown,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Rae H. Block,
(b) Address 6102 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/44. (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) JUN 15 1944 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th. 1944 at 5.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to June 14 1944, and that I last saw him alive on June 14 1944.

Immediate cause of death	Duration
Due to Coronary thrombosis	1 day
Due to Coronary artery disease arterio-sclerosis	3 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick Lenz M. D.
Address Temple Garden Apts. Date signed 6/15/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

Registered No. G 18176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 d/ Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Riderwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riderwood
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary H. Stevens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Allen Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/3/1884

8. AGE: Years	Months	Days	If less than one day
59	8	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hafmeister
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Zindle
15. Birthplace Germany

16 (a) Informant Husband
(b) Address Riderwood, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-44 (month) (day) (year)
(c) Cemetery or crematory Carroll Chapel Cem.
Location Baltimore Co. Maryland

18 (a) Funeral director Stewart Mortuary
(b) Address 1084 North Ave.

JUN 15 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 June 1944 at 8:32 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 June 1944 to 13 June 1944 and that I last saw h[illegible] alive on 13 June 1944.

Immediate cause of death	Duration
Cerebral thrombosis (?)	3 days
Due to Diabetic acidosis	3 days

Other Conditions (1) Diabetes
(2) Congenital stricture
(Include pregnancy within 3 months of death)
Date of operation 6-11-44
Major findings of operation: Cauterization & hypertrophy of prostatic mucosa.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Mungatayo Jr. M.D.
Address 332 E. University Pkwy Date signed 6/13/44

G 18177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 813a Registered No. G 18177

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 N. Carrollton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Carrollton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Waters

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Preston Waters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-1885.

8. AGE: Years	Months	Days	If less than one day
59	-	2	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Preston Waters
13. Birthplace Chester S.C.

MOTHER
14. Maiden Name Annie Davis
15. Birthplace S.C.

16 (a) Informant Arthur Waters
(b) Address 28 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-44 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem Cem
Location Arlington Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) JUN 15 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 1944 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1944 to 6/19 1944 and that I last saw h[illegible] alive on 6/12 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Ext to emplegia

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Adelsberg M. D.
Address 113 Harlem Date signed 6/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No. G 18173

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/21/44

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1208 E. Lexington Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH THOMAS SIMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie(Simpson)

Maiden Name: Davis 6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1901

8. AGE: Years 43 | Months 2 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Suffolk, Va. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Merchant Marine

FATHER — 12. Name John Simpson; 13. Birthplace Suffolk, Va.

MOTHER — 14. Maiden Name Hattie ?; 15. Birthplace Suffolk, Va.

16 (a) Informant Records, U. S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery - Location Annapolis Rd.

18 (a) Funeral director Lee Adams

(b) Address 4644 York Rd.

19 (a) JUN 19 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION P.

20. DATE OF DEATH June 13, 1944, at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21, 1944, to June 13, 1944, and that I last saw him alive on June 13, 1944.

Immediate cause of death 1. Combined chronic glomerular nephritis and nephrosclerosis; 2. Marked cardiac hypertrophy and dilitation, mostly left ventricle. — Duration: Unk. / Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward E Adams. M. D.

Address Baltimore, Md. Date signed 6/14/44

VS 150

MS-51844

G 18179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V181

G 18179 Registered No.

Every item of information should be carefully examined and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Wardley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellow Ratcliff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
19			hr. min.

9. Birthplace Pageland S C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business City of Balto

FATHER
12. Name Peter Ratcliff
13. Birthplace S C

MOTHER
14. Maiden Name Elizzie Ratcliff
15. Birthplace S C

16 (a) Informant Mrs. Sinclair
(b) Address 422 Wardley St

17 (a) Shipped (b) Date thereof 6 16 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sherwood
Location S C

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) JUN 15 1944 (b)
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1944, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns, second and third degree, entire body.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/14/44 7:45 A.M.
(b) Where did injury occur? Gate Club Country Club Ext Upland Rd.
(c) Did injury occur at home, on farm, industrial place, in public place Public While at work? No.
(d) Means of injury While lighting a cigarette flame ignited gasoline

23. Signature N. T. Wollenweber M.D.
Medical Examiner.
Date signed June 15, 1944

VS 151

G 18180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. [redacted] 18180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 N. Howard ave (Rooming)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Hazel Walker
6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.): Mar. 27, 1878

8. AGE: Years 66 | Months 2 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace: Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation: Bookkeeper
11. Industry or business:

FATHER
12. Name: Thomas H. Walker
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Ann Gravenor
15. Birthplace: Md.

16 (a) Informant: Mrs. Wm H. Walker
(b) Address: Havre de Grace, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 18 1944 (month) (day) (year)
(c) Cemetery or crematory: Cambridge Cem.
Location: Dorchester Co. Md.

18 (a) Funeral director: R. Madison Mitchell
(b) Address: Havre de Grace, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15- 1944, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy - Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D.
Medical Examiner.
Date signed 6-15-44

G 18181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51c

G 18181

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Inner Circle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Brooklyn.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Inner Circle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Russia

3 (a) FULL NAME John N. Karpook

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-3737

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9-1889

8. AGE: Years 55. | Months 5. | Days 34 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business General Brick Co.

FATHER
12. Name Aktok Karpook
13. Birthplace Russia

MOTHER
14. Maiden Name Mapka Karpook
15. Birthplace Russia.

16 (a) Informant Sophia Gerzuski
(b) Address 1816 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June. 16 1944 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial
Location taylor ave

18 (a) Funeral director Wendell J DIPPEL
(b) Address 312 S. Highland ave

19 (a) (Date rec'd by registrar) (b)

JUN 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944 at 2.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to June 12 1944
and that I last saw him alive on June 12 1944

Immediate cause of death Coronary Thrombosis
Carcinoma of Prostate

Duration 8 weeks

Due to Embolism Ulcerated 1 1/2 yrs.
of prost Testicle

Due to

Other Conditions Metastasis of prost Pelvis

(Include pregnancy within 3 months of death)

Date of operation July 1943

Major findings of operation Embolism
Carcinoma of prost Testicle

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben D. Yorke M.D.

Address 700 Fleming Pl. Date signed 6/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

18182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 18182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3620 W Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-8
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 W Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Weissman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: Rag Business

FATHER
12. Name: Nathan Weissman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dorothy ?
15. Birthplace: Russia

16 (a) Informant: Jennie Weissman
(b) Address: 3620 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 16, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Young Men Cem
Location: Windsor Mill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19. Date received (month) (day) (year): JUN 16 1944 (Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1944, at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942, to June 15 1944, and that I last saw him alive on June 14 1944.

Immediate cause of death	Duration
Coronary Thrombosis	14 hours
Due to Arteriosclerosis	12 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Cohen M. D.
Address 1804 Eutaw Place Date signed 6/16/44

C 18183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. C 18183

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 N. Bethel st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Curley st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emma V. Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1872

8. AGE: Years	Months	Days	If less than one day
72	0	17	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Chas. Mitchell
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Robert A. Smith
(b) Address 1514 E. Lanvale st

17 (a) Burial (b) Date thereof 6/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul st.

JUN 16 1944 (Date rec'd registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1944 at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to June 14 1944 and that I last saw h[illegible] alive on June 8 1944.

Immediate cause of death Arteriosclerotic C-V disease — Duration years

Due to

Due to

Other Conditions Severe Rheumatoid arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Granger M.D.
M. D.

Address 1402 E. Lanvale Date signed 6-15-44

G 18184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C. Registered No. G 18184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia L. Rush

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1883

8. AGE: Years 61 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Dubrey
13. Birthplace Canada

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles P. Rush
(b) Address 1723 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JUN 16 1944 (Date rec'd by registrar) (b) [illegible] Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1944, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/13/44 11:55 P. 12/5 M.
(b) Where did injury occur? ~~the south side of~~ Greenmount Ave at Lanvale Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury struck by automobile (Burn, fall, firearm, poison, etc.)

23. Signature [illegible] M.D. Medical Examiner.
Date signed 6-14-44

C 18185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered Number C 18185

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 E. 33rd st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 E. 33rd st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa A. Parr

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband William A. Parr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22nd 1868

8. AGE: Years	Months	Days	If less than one day
75	8	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Baldus
15. Birthplace Unknown

16 (a) Informant Estella A. Parr
(b) Address 1813 E. 33rd St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/17/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JUN 16 1944 (Date rec'd by registrar) Milton Miller M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 1944 at 7.30 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 19 44, to June 13 19 44, and that I last saw h. alive on June 6 19 44.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to	
Due to Chr. Valvular Heart Disease	8 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. V. Regan
Address 1508 E. 33rd St Date signed 6/16/44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46c

Registered No. 18186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4224 Harford ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4224 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hawkins Merritt

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1853

8. AGE: Years 90 | Months 6 | Days 15 | If less than one day, hr. min.

9. Birthplace A.A. Co. Md. (Town, county, and state)

10. Usual Occupation Farming

11. Industry or business Self

FATHER
12. Name Thomas H. Merritt
13. Birthplace a.a. Co. Md.

MOTHER
14. Maiden Name Eliza A. Hawkins
15. Birthplace a.a. Co. Md

16 (a) Informant John R. Hutson
(b) Address 2821 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location a.a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) 217 St. Paul st

19 (a) JUN 16 1944 (Date rec'd by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1944 at 5:2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944 to June 14 1944 and that I last saw h[illegible] alive on June 14 1944.

Immediate cause of death: Duodenal Carcinoma — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X. L. Eagle M. D.
Address 5106 Harford Rd Date signed 6-15-44

S 13187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G 13187 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1

(c) Hospital or institution: St. Joseph's Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 408 E. 21st. Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Charles Michael ~~Morone~~ Morone

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1858

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Merle.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 - 1906

8. AGE: Years 38 Months 1 Days 22 If less than one day hr. min.

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation Welder.

11. Industry or business

FATHER: 12. Name Mr. Charles Morone Sr.

13. Birthplace Italy

MOTHER: 14. Maiden Name Mary Felicia Nardone

15. Birthplace Italy

16 (a) Informant Merle Morone

(b) Address 408 E. 21st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-1944 (month) (day) (year)

(c) Cemetery or crematory Mount Holy Redeemer

Location Belair Road

18 (a) Funeral director Joseph Fazace Inc.

(b) Address 2015 Fredemont ave

JUN 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 5:53 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 6/15/1944. and that I last saw him alive on 6/15/1944.

Immediate cause of death Septicaemia.

Due to Staphylococcus Viridans Subacute Bacterial Endocarditis.

Due to

Other Conditions Cerebral Embolus Rt. Aphasia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Klyanovsky M.D.

Address St. Josephs Hosp. Date signed 6-15-44

G 18188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G 18188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hos. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 Holmes ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Karpa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emile Karpa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Morris
13. Birthplace Russia

MOTHER 14. Maiden Name Florence
15. Birthplace Russia

16 (a) Informant Maurice Karpa - Son
(b) Address 3220 Benlett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-44 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cem
Location Phila. Rd & Hamilton Ave

18 (a) Funeral director Jack Levenberg
(b) Address 1439 E. Balto

19 JUN 16 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15-44, 1944, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Cervical Vertebra

Due to

Other Conditions: Lacerations, bruises, bruised brain, Fractured fibula
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 13/4
(a) Date of injury 6-14-44 at 8.20 P.M.
(b) Where did injury occur? Pennsylvania R/R nr. Seven Falls
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by automobile

23. Signature Howard J. Weddell M.D.
Medical Examiner.
Date signed 6-14-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 18189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 18189 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethelem-Fairfield Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.OA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Friedmann

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Shipyard Worker

11. Industry or business

FATHER
12. Name Morris Friedmann
13. Birthplace Russia

MOTHER
14. Maiden Name Ada Pearlman
15. Birthplace Russia

16 (a) Informant Morton Friedmann
(b) Address 2513 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Memorial Park
Location Berkley & Pasadena Pike Rd.

18 (a) Funeral director Joseph Levine Inc
(b) Address 1439 E. Baltimore St

19 (a) JUN 16 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 2 15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed June 15 1944

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18190 Cocilovo ✓ C 18190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard St + Madison
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 W. Garrison Ave. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius Frank Cocilove
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lena Cocilove
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1883

8. AGE: Years 60 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Salvatore Cocilovo
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Mascari
15. Birthplace Italy

16 (a) Informant Lena Cocilove
(b) Address 2816 Garrison Ave.

17 (a) Burial (b) Date thereof 6/19/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Md.

19 JUN 16 1944 (Date received by registrar) (Signature of registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1944, at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1944 to 6/16 1944, and that I last saw h[illegible] alive on 6/16 1944

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 6/16/44 M. D.

(over)

MAROK

G 18191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1140

G 18191 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mediciant Lyingin
(c) Hospital or institution Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Lemwood Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Mark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Louise Mark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3 1867

8. AGE: Years 76 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Proprietor

11. Industry or business

FATHER
12. Name John J. Mark
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Freckles
15. Birthplace Bohemia

16 (a) Informant Louise Mark
(b) Address 515 N. Lemwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John A. Hoban
(b) Address 3010 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1944 at 1 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1944 to 6/12 1944 and that I last saw him alive on 6/12 1944

Immediate cause of death Lung Abscess — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers, M.D.
Address Md. Gen. Hosp. Date signed 6/12/44

VS 150

G 18192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G 18192

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1726 Lamont Avenue

(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1300 Wilcox Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bena J. Gravenstine

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Walter Gravenstine

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 13, 1875

8. AGE: Years 69 | Months 2 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER — 12. Name William Arch

13. Birthplace Germany

MOTHER — 14. Maiden Name Susan Summers

15. Birthplace Pennsylvania

16 (a) Informant Mr. Andrew Cioeff (Son)

(b) Address 1300 Wilcox Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17, 1944 (month) (day) (year)

(c) Cemetery or crematory Western

Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

JUN 16 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 1944 at 2.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1944 to 6/13 1944 and that I last saw h[illegible] alive on 6/13 1944

Immediate cause of death: Carcinoma - Stomach — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph S. Bloom M.D.

Address 206 E. Preston St. Date signed 6/15/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

C 18193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gineal Hosp. 1358
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2062 Rockrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Rooney.

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	widower

6 (b) Name of husband or wife Elizabeth Rooney.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 6 1879

8. AGE: Years	Months	Days	If less than one day
65	2	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farm Hand.
11. Industry or business

FATHER
12. Name Eugene Rooney.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Lucy Hill.
15. Birthplace Maryland.

16 (a) Informant Laura Knight.
(b) Address 2062 Rockrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17/44 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampstead

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Edmondson Ave.

JUN 16 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1944, at 11 57 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1944, to June 15 1944, and that I last saw him alive on June 15 1944.

Immediate cause of death: Cardiac Failure Decompensation — Duration ?
Due to Arteriosclerotic Cardio Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —
23. Signature Irving Taylor M.D.
Address WBGH Date signed 6/16/44

C 18194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C 18194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Huntingdon ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Huntingdon ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer W. Bush, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-9823

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hilda I. Bush

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) May 3, 1898

8. AGE: Years	Months	Days	If less than one day
46	1	12	....hr. ....min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Checker

11. Industry or business Balto Transit Co.

FATHER
12. Name Henry Bush.
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Kretz
15. Birthplace Pa.

16 (a) Informant Hilda I. Bush.
(b) Address 2811 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Hanover, Pa.

18 (a) Funeral director Chenowith & Sonoraw
(b) Address 3615-17 Edmondson Ave.

19 JUN 16 1944 (Date rec'd by Registrar) (b) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 ~ 1944, at 7:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D. Medical Examiner.
Date signed 6-15-44

VS 151

G 18195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G 18195

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Annapolis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Annapolis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis H. Lowey Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eleanor B. Lowey

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 31 1889

8. AGE: Years: 74 | Months: 8 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER — 12. Name: Lewis H. Lowey Sr
13. Birthplace: Balto. Md.

MOTHER — 14. Maiden Name: Rosanne McLaughlin
15. Birthplace: Maryland

16 (a) Informant: Eleanor B. Lowey
(b) Address: 2007 Annapolis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/16/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd. Irvington

18 (a) Funeral director: F. B. Wippert & Son
(b) Address: 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13/1944, at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 13 1944, and that I last saw him alive on June 13 1944.

	Duration
Immediate cause of death: Hemorrhage of Bowel	3 days
Due to: Cancer of Liver	3 mo
Due to: Bronchitis	4 mo
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: R S Adams M.D.
Address: 2159 Hallows Lane Md Date signed: 6/16/44

G 18196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V93D

G 18196 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2143 Holline St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2054
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2143 Holline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Martha M. Davis
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept 26-1867

8. AGE: Years	Months	Days	If less than one day
76	8	18	19 — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpet Changer
11. Industry or business —

FATHER
12. Name Thomas A. Davis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Allen
15. Birthplace Baltimore, Md.

16 (a) Informant Martha M. Davis
(b) Address 1015 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/44 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Baltimore, Md.

18 (a) Funeral director J. A. Pappert & Son
(b) Address Baltimore, Md.

19 JUN 16 1944 (Date received by Registrar) (b) Thomas J. Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15th 1944, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944 to June 13 1944, and that I last saw him alive on 6/13 1944.

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D. M. D.
Address 20 30 Wilkens Date signed 6/14/44

G 18197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18197

TN. 10991 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs & 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Homeless (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No) ✓

If yes, name country Ireland

3 (a) FULL NAME Michael Kittrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1863

8. AGE: Years	Months	Days	If less than one day
81	3	19	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Micheal Kittrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Sheridan
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/44 (month) (day) (year)

(c) Cemetery or crematory Locust Point

Location Lawyers Hill Road

18 (a) Funeral director John F. Tarrytown

(b) 1344 Light St.

19 (a) JUN 16 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11th, 1944 19 , at 955 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14/39 to 6/11/1944, and that I last saw him alive on 6/11/1944.

Immediate cause of death Pneumonia / Duration 10 d.

Due to

Due to

Other Conditions ASCVD; emphysema, st. fem. artery. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Dx

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seyman M. D.

Address 13 C 14 Date signed 6/15

C 18198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

C 18198

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 W. Lanvale St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 2
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Cohen Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-18-9760

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thelma Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1909

8. AGE: Years 34 Months 36 Days 5 If less than one day — hr. — min. 24

9. Birthplace Washington, D. C. (town, county, and state)

10. Usual Occupation Porter

11. Industry or business Sales shop

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Annable
15. Birthplace

16 (a) Informant Thelma Wilson
(b) Address 1523 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 17 44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Preastman St

19 (a) (b) Registrar

JUN 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14 1944 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 1944 to 6-14 1944 and that I last saw h[illegible] alive on 6-14 1944.

Immediate cause of death: (a) Lobar Pneumonia — Duration 3 Days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. H. Pifott M. D.
Address 1536 W. Lanvale St Date signed 6-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

C 13199 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: 15242
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Yospy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Whire	Married

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Samuel Berman
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Emanuel Yospy
(b) Address 3907 Edgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Southern Ave
Location Souther n Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (b)

JUN 16 1944

VS 150

MEDICAL CERTIFICATION 1.20

20. DATE OF DEATH June 16, 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to June 16 1944 and that I last saw h. ALR alive on June 15 1944

Immediate cause of death: Acute Dilation Left Cardiac Ventricle
Due to: Diabetes Mellitus — Duration: Few Yrs
Due to: Coronary Thrombosis — Duration: Few Yrs
Due to: Cerebral Embolus — Duration: 2 weeks
Due to: Hypostatic Pneumonia — Duration: 6 days
Other Conditions — Duration: 2 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A Weinstock M. D.
4603 Park Heights Ave Date signed 6/16/44

455550 G 18200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 18200 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Tilghman (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William R. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-92

8. AGE: Years 51 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Tilghman, Md (Town, county, and state)

10. Usual Occupation FISHERMAN

11. Industry or business

FATHER 12. Name Louis P Lee

13. Birthplace Md

MOTHER 14. Maiden Name Mary V Harrison

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)

(c) Cemetery or crematory Location Tilghman, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Easton, Md.

19 JUN 16 1944 (Date rec'd by registrar) (b) Hamilton Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 330 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944, to June 15 1944, and that I last saw him alive on June 15 1944.

	Duration
Immediate cause of death ATELECTASIS AND BRONCHOPNEUMONIA OF ENTIRE RIGHT LUNG	2 days
Due to HEMORRHAGE INTO CERVICAL SPINAL CORD & ? BRAIN	7 days
Due to FRACTURE-DISLOCATION OF 2ND & 3RD CERVICAL VERTEBRAE	7 days
Other Conditions PARAHYTIC ILEUS ARTERIOSCLEROSIS (Include pregnancy within 3 months of death)	

Date of operation NONE

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence JUNE 8, 1944 about A. M
(c) Where did injury occur? AT DOCKS, BALTIMORE, MD. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ON BOARD SHIP While at work? YES (Specify type of place)
(e) Means of injury FELL IN BOAT, STRUCK HEAD ON RAIL
23. Signature Edward L. Bauman
Address Johns Hopkins Hosp. Date signed 6-15-44 M. D.

VS 150 Released to Hosp. by Med. Examiner Dr. Mallett aff. Howard J. Mallett MD

G 18201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 18201

88119

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 713 Port St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Frances Pohl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19 or 9th 1867

8. AGE: Years 76 | Months 6 | Days 12 or 22? | If less than one day hr. min.

9. Birthplace Czecho Slovikia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Joseph Slovahla or Shwehla

13. Birthplace Czecho Slovikia

MOTHER

14. Maiden Name Veronica Chembosette Chemoscott or

15. Birthplace Czecho Slovikia

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral dire Charles E. Schimunek

(b) Address 2601-03 East Madison St.

19 (a) JUN 16 1944 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13- 1944, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1944 to 6-13 1944 and that I last saw h- alive on 6-13 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Mathias

Address B. C. H. Date signed 6/18/44

18202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58a

G 18202

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 Jackson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard D. Carson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1940

8. AGE: Years 3 | Months 07 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER / FATHER

12. Name Howard D. Carson, Sr.

13. Birthplace Phila., Pa.

MOTHER

14. Maiden Name Elorsi Alderton

15. Birthplace Ohio

16 (a) Informant Father

(b) Address 1734 Jackson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Memo
Location Glen Bernie

18 (a) Funeral director William M Mareck

(b) Address 715 Light St.

JUN 16 1944 Baltimore, Md.
Registrar

VS 150

MEDICAL CERTIFICATION

19. DATE OF DEATH 6/13 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1944 to 6/13 1944, and that I last saw h[illegible] alive on 6/13 1944

Immediate cause of death: Cardiac failure — Duration: Life

Due to ~~Bronchopneumonia~~ Rheumatic fever — Duration: 14 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Rheumatic Heart Disease, Chronic Endocarditis, Mitral Stenosis & Insufficiency.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(Specify one of places)
(e) Means of injury

23. Signature R. Mgh. Crosby

Address Mercy Hosp. Date signed 6/13

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 18203 ✓ G 18203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4213 Cantana Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Cantana (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Barbara Schafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1901

8. AGE: Years 43 | Months 2 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation secretary

11. Industry or business

FATHER
12. Name Mathias G. Schafer
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary S. Tremmel
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Schafer
(b) Address 4213 Cantana Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rygl
(b) Address 530 E Harford Rd.

19 (a) [illegible] (b) [illegible]

JUN 16 1944 Hunter for Mathews, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1944 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to June 14 1944, and that I last saw her alive on June 13 1944.

Immediate cause of death Carcinomatosis — Duration 1 year

Due to Carcinoma

Due to Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Kinzer M. D.
Address 2700 Harford Rd Date signed June 14 1944

G 18204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18204 Registered No.

80a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore #6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 5402 Summerfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robin Mark Seaton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6. 1942

8. AGE: Years	Months	Days	If less than one day
2	5	8	hr. min.

9. Birthplace Baltimore, md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James A. Seaton
13. Birthplace Baltimore, md.

MOTHER
14. Maiden Name Maria T. Jarabek
15. Birthplace Baltimore Md.

16 (a) Informant James A. Seaton Gdf
(b) Address 5402 Summerfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 17 44 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore

18 (a) Funeral director Philip Herwig Son
(b) Address 2124 Oldmanst

19 (a) (b) Hamburger Baltimore, Md

JUN 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1944, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1944, to 6-14 1944, and that I last saw him alive on 6-14 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pneumonia + Septicemia	
Due to Staphylococcus Infection	
Other Conditions Encephalitis	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Morris, md M. D.
Address 1 W Ma Jurisdiction

C 18205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

C 18205 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 Longwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Longwood St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Clara Wiesa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: albert Wiesa

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 3-1880

8. AGE: Years 64 | Months | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

MOTHER / FATHER

12. Name Charles Schleder

13. Birthplace Germany

14. Maiden Name Christina Megan

15. Birthplace Germany

16 (a) Informant Cecil R. Litten

(b) Address 1136 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-44 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location Edmondson Ave. B/Eo,

18 (a) Funeral director George A. Misbaum

(b) Address 400 Old York Road

(Date received by registrar) JUN 16 1944 (b) Registrar's No. 18205

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1944, at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1943 to June 14th 1944, and that I last saw h.er alive on June 13 1944

Immediate cause of death	Duration
Coronary occlusion	5 minutes
Due to Chr. myocarditis	5 yrs
Due to arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott

Address 1136 Poplar Grove St Date signed 6/15/44

G 18206 ✓ G 18206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coloest age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139 S Eutaw St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 S Eutaw St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Dora E. Pieper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Herman Pieper

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov 24-1883

8. AGE: Years	Months	Days	If less than one day
60	6	22	21 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Rosing
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhelmine Trumpler
15. Birthplace Md.

16 (a) Informant Herman Pieper
(b) Address 139 S Eutaw St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 17-1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director J. A. Mispagel & Son
(b) Address 1850 W. Baltimore St

JUN 16 1944 rec'd by registrar — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1944 to June 15 1944, and that I last saw him alive on June 14 1944.

Immediate cause of death
Coronary Occlusion
Due to Arteriosclerosis
Due to
Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Norbert C. Pitsch
Address 15 W Mulberry Date signed 6/16/44
Norbert C. Pitsch

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

C 18207

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Maemple Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town, write "Not in city" and give town)
(d) Street No. 2605 Maemple Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie May Wellsworth

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Wellsworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 - 1878

8. AGE: Years	Months	Days	If less than one day
66	—	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name August Biermann
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Jones
15. Birthplace Germany

16 (a) Informant Charles Wellsworth
(b) Address 2605 Maemple Lane

17 (a) Burial (b) Date thereof June 19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Baltimore Md.

18 (a) Funeral director George E. Schwab
(b) Address 2101 Eastern Ave

19 (a) Filed by [illegible] Registrar

L6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1944 to June 15 1944, and that I last saw h[illegible] alive on 6/15 1944.

Immediate cause of death Arteriosclerotic cardio vascular disease — Duration 2 yrs

Due to

Due to

Other Conditions Bronchopneumonia — 1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.

Address 20 30 Wilkens Ave Date signed 6/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94'a

C 18208 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. Dogwood Ridge Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. Santa (Edward C. Sauter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Victoria Santa

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.) July 24, 1876

8. AGE: Years	Months	Days	If less than one day
67	10	21	hr. min.

9. Birthplace: Woodlawn Baltimore Co. Md
(Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER
12. Name: Christian Santa
13. Birthplace: Woodlawn, Md.

MOTHER
14. Maiden Name: Georgianna Powell
15. Birthplace: Virginia

16 (a) Informant: Mrs. Victoria Santa
(b) Address: Dogwood Ridge Rd. Balto. 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17, 1944 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cemetery
Location: Woodlawn Cemetery

18 (a) Funeral director: E. W. Cameron
(b) Address: 4510 Liberty Heights Ave.

19 (a) JUN 16 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 1944 at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1944 to 6/15 1944 and that I last saw h[illegible] alive on 6/15 1944

Immediate cause of death: Coronary thrombosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. Carl Myers M.D.

Address: Md. Gen. Hosp. Date signed 6/15/44

C 18209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935

C 18209

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Brandywine (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Lippett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-04

8. AGE: Years	Months	Days	If less than one day
40		21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER — 12. Name Elizabeth Lippett

13. Birthplace PERRYMAN THOMAS (Md)

MOTHER — 14. Maiden Name SARA BELL

15. Birthplace (Md)

16 (a) Informant RECORDS

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvel

Location Upper Marlboro Md

18 (a) Funeral director Pickett Bros

(b) Address Upper Marlboro, Md.

6 1944 (b) by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16- 1944, at 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1944, to 6-16 1944, and that I last saw h[illegible] alive on 6-16 1944

Immediate cause of death Uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Eberhart M.D.

Address Johns Hopkins Date signed 6/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18210

JO #88327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

Registered No. 18210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S. Quail St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1887

8. AGE: Years	Months	Days	If less than one day
56	-5-	29	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kern (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Smith (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave. Rd

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave

19 JUN 16 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944, to 6-14 1944, and that I last saw h/m alive on 6-14 1944

Immediate cause of death Carcinoma of liver — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hettman M.D.
Address B.C.H. Date signed 6/15/44

G 18211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G 18211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 Mc Phail
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. 156 Mc Phail St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth A. Stockum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 15th 1923

8. AGE: Years	Months	Days	If less than one day
21	2	1	hr. min.

9. Birthplace Lititz Pa
(Town, county, and state)

10. Usual Occupation Fin Sorter

11. Industry or business Bethlehem Steel

FATHER
12. Name William A. Stockum
13. Birthplace Md.

MOTHER
14. Maiden Name Miriam Cassard
15. Birthplace Pa

16 (a) Informant William A. Stockum
(b) Address 156 Mc Phail St

17 (a) Burial (b) Date thereof 6/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 847 St. Paul St.

19 (a) JUN 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16th 1944, at 3 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to June 16 1944, and that I last saw h[illegible] alive on June 15 1944.

Immediate cause of death	Duration
(a) Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions Tuberculosis Ulcer of Stomach	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1151 W Lexington Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15212 G [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. G 15212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2017 Oak Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 53
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Oak Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MAUD GODWIN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1874

8. AGE: Years 69 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Sidney W. Ritter
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden Name: Anne E. Hurtt
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mr. James E. Godwin
(b) Address: 2017 Oak Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (b)

JUN 17 1944 Registrar, Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16/ 1944 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7/44 19 , to 6/16 1944 and that I last saw h[illegible] alive on 6/14 1944

Immediate cause of death: Cerebral Hemorrhage
Antecedent
Due to: Cardiac Enlargement

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 9 days 10 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W. E. James M.D.
Address 2818 Eutaw Pl. Date signed 6/17/44

C 18213

C 18213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C 18213
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 N.Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N.Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes A.Nixdorff,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife David T.Nixdorff,

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) May 8.1875

8. AGE: Years 69 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace BalTimore Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name John Asendorf,
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Lersh,
15. Birthplace Baltimore Md.

16 (a) Informant David T.Nixdorff,
(b) Address 320 N.Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19.1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director George W.Little,
(b) Address 2700 Edmondson Ave,

19 (a) JUN 17 1944 (Date rec'd by Reg.) Hamilton M. Wilmarth, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 15 1944, 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1944 to June 15 1944, and that I last saw h[er] alive on June 15 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 15 Day.

Due to: Hypertension Cardio vascular disease — 2 years.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hebert F. Pullman M. D.

Address 6 E Biddle St Date signed June 14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully answered. Physicians: please write the exact cause of death clearly and legibly. Every item of information should be careful correct age is especially important.

18214

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 144a

Registered No. G 18214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Josephs Hospital
(c) Hospital or institution: Baltimore Md. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 2 Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Slaters Ave Fullerton MD
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Edna M. Knauer.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Joseph Knauer.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-15-11

8. AGE: Years 32 Months 6 Days 1 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nicholas Smith
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Caroline Mollhausen
15. Birthplace Balto. Co. Md.

16 (a) Informant Joseph Knauer
(b) Address 40 Slater ave. Fullerton

17 (a) Burial (b) Date thereof June 18 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Lawson Funeral Home
(b) Address 7401 Belair Road

19 (a) JUN 17 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1944 to 6/16 1944, and that I last saw h[illegible] alive on 6/16 1944

Immediate cause of death Severe Convulsions — Duration

Due to Eclampsia of pregnancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which [illegible] be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William E Cheidi
Address St Josephs Hospital Date signed 6/16/44 D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937

G 18215
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara A. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3. 1880

8. AGE: Years: 64. | Months: 1 | Days: 13. | If less than one day: hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Gas Helper

11. Industry or business Boiler.

FATHER
12. Name Unknown
13. Birthplace W. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace W. Va.

16 (a) Informant Mrs. Clara A. White
(b) Address 907 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory Hillcrest Cem
Location Cumberland, Md.

18 (a) Funeral director Chas. E. Cowan & Son
(b) Address 913 Hollins Street

19 (a) JUN 17 1944 (b) [illegible] Registrar
(Filed rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16. 1944 at 3.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1943 to June 16 1944 and that I last saw him alive on June 16 1944.

Immediate cause of death	Duration
Hypertension Cardio vascular Disease	?
Due to	
Due to	
Other Condition Cerebral Hemorrhage	5/3/42

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Carey Rostring M. D.
Address 316 W Lonsdale St Date signed 6/16/44

G 18216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18216
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 James St.
(c) Hospital or institution: 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 James Street (If rural give location)
(e) Citizen of foreign country? James (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles S. Wagner

6 (c) If alive, give age 51. years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1900

8. AGE: Years 43 | Months 5 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name Paul Forbringer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Charles S. Wagner
(b) Address 1231 James Street

17 (a) Burial (Burial, cremation, or removal) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Belair Rd. Md.

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) JUN 17 1944 (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944 at 1 30 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallansweber M.D.
Medical Examiner.

Date signed 6-17-44

C 18217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

C 18217 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Cause age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 E. 22½ St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 E. 22½ St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jno Price
13. Birthplace South Carolina

MOTHER
14. Maiden Name Johnnie Glen
15. Birthplace South Carolina

16 (a) Informant Mrs Price
(b) Address 408 E 22½ St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

JUN 17 1944 (Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 16 1944 and that I last saw h alive on 19

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C P Julian
Address 434 E 22nd St Date signed 6-17-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C 18218

C 18218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked before writing. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 N. Carey at
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) Maryland County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 N. Carey at.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife William Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1869.

8. AGE: Years	Months	Days	If less than one day
75 70	5	14.	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Dont Know
13. Birthplace Va.

MOTHER
14. Maiden Name Henrietta Haynie
15. Birthplace Va

16 (a) Informant Henry Green
(b) Address 1314 N. Carey St.

17 (a) Burial (b) Date thereof 6/17/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. L. Kelson
(b) Address 1303 Pennsylvania Ave

JUN 17 1944 (b) Baltimore, Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1944; at 7:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1944 to 6/14 1944 and that I last saw her alive on 6/14 1944

Immediate cause of death	Duration
Acute myocarditis	2 wks
Due to Interstitial Nephritis	
Due to Hypertension	4 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Guyon M. D.

Address 562 N. Carlington Ave Signed 6/16/44

VS 3

C 18219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C 18219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure that each item is correct and complete. Where there is no correct answer, write none or unknown. Where an item is not applicable, write it. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Chilham Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob B. Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of ~~husband~~ wife Leah Fine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20 1865

8. AGE: Years	Months	Days	If less than one day
78	6	26	hr. 40 min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Retired Clothing
11. Industry or business Tailor

FATHER
12. Name A. Myer Fine
13. Birthplace Lithuania

MOTHER
14. Maiden Name Shula Barret
15. Birthplace Lithuania

16 (a) Informant Mrs. Sylvia Kremer
(b) Address 2202 Chilham Rd. Mother Mother-in-law

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Bonar Israel
Location Balto. Md.

18 (a) Funeral director Edward Sonnheim & Son
(b) Address 1902 Eutaw Place

(a) JUN 17 1944 Hillsdale Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944 at 12:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 16 1944, and that I last saw him alive on June 16, 1944

Immediate cause of death	Duration
Circulatory failure	36 hr.
Due to Cardiac failure and toxemia of intestinal stasis	96 hr. 48 hr.
Due to Arteriosclerotic Myocarditis	20 yrs.
Other Conditions Carcinoma of transverse colon. Malnutrition. (Include pregnancy within 3 months of death)	

Date of operation June 13, 1944
Major findings of operation: Obstruction due to Carcinoma of transverse Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Zimm Berry M.D.
Address Mercy Hospital Date signed 6/16/44

18220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18220

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3905 Old York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret E. Kaspar

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles L. Kaspar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/1871

8. AGE: Years 73 | Months 5 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Wtlliam H. Ryninger
13. Birthplace Pa

MOTHER
14. Maiden Name Mary E. Fell
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles L. Kaspar, Jr. (Son)
(b) Address 3905 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

JUN 17 1944 (b) Hunting & Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1944, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to 6/16 1944, and that I last saw h-- alive on 6/16 1944.

Immediate cause of death: Glandular Tuberculosis (cervical) Tuberculosis — Duration 18 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Moody

Address 1402 Parkave, Date signed 6/19/1944

18221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 153

G 18221 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution: U. S. Marine Hospital, Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 6/8/44 8:45 AM

(e) Length of stay in Baltimore (yrs., mos., or days) Just Arrived

12-6

2. USUAL RESIDENCE OF DECEASED:

(a) State Va. (b) County

(c) City or town Berkley, Norfolk (If outside city or town limits, write RURAL and give town)

(d) Street No. 428 Greig Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WEBSTER SMITH

3 (b) If veteran, name war: -

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Downing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/1880

8. AGE: Years	Months	Days	If less than one day
63	9	16	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Deckhand

11. Industry or business Merchant Marine

FATHER

12. Name SMITH, Cincinnati

13. Birthplace Va.

MOTHER

14. Maiden Name Ardenia ?

15. Birthplace N. C.

16 (a) Informant Records, U.S.Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 6-18-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Berkley

Location Norfolk, Va.

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Belvidere St.

JUN 17 1944 Katie R. Williams M.D. (Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH June 15, 1944, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1944 to June 15, 1944, and that I last saw him alive on June 15, 1944.

Immediate cause of death: Terminal bronchial pneumonia — Duration: Unk.

Due to: Epidermoid carcinoma of the skin of perineum with extension to the bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S H Epstein M. D.

Address Baltimore, Md. Date signed 6/16/44

MS-53441

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

~~G 18222~~ 4956 146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18222 Registered No. 1222a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N C (b) County
(c) City or town Wilmington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N. 7th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David S Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	BLACK	MARRIED

6 (b) Name of husband or wife Essie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-92

8. AGE: Years	Months	Days	If less than one day
51	8	0	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Beer Tavern Owner
11. Industry or business

FATHER 12. Name Thomas Miller
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/44 (month) (day) (year)
(c) Cemetery or crematory Wilmington
Location N. C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

JUN 17 1944 (Date rec'd) (Registrar's signature) Wilmington, N.C.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 8 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to June 15 1944, and that I last saw him alive on June 15 1944.

Immediate cause of death Pulmonary Embolus — Duration

Due to Thrombo phlebitis

Due to

Other Conditions Hernia, Post Operative (Include pregnancy within 3 months of death)

Date of operation June 3, 1944

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Hayes M.D.
Address J. H. H. Date signed 6/16/44

G 18223 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210 G 18223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution: General German Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie S. Dankmeyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29 1867

8. AGE: Years 77 | Months 7 | Days 13 | If less than one day hr. min. 17

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John F. W. Dankmeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmine Meyer
15. Birthplace Germany

16 (a) Informant General German Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19/44 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Balto. Md

18 (a) Funeral director Harry A. Webster
Address 4101 E. Monument Ave

JUN 18 1944 (Date received) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944 at 5.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1/43 19 to June 16/44. and that I last saw h er alive on June 16/44.

Immediate cause of death | Duration

Mitral Regurgitation 30 Yrs.

Due to

Due to

Other Conditions Chronic Unknown.
Paranchymatous Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wells Lemmon M. D.
Address 433 Hamilton Ave. Date signed June 17/44.

G 18224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

G 18224

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4013 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O'Neill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband ~~or wife~~: John O. O'Neill
6 (c) If alive, give age —years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1860

8. AGE: Years 84 | Months 4 | Days 19 | If less than one day — hr. — min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name McClain Harrington
13. Birthplace Ireland

MOTHER — 14. Maiden Name Ellen Courteney
15. Birthplace Ireland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
Address 805 N. Calvert Street

19 (a) JUN 18 1944 (Date rec'd by Registrar) (b) for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1944, at 9.00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/5 1944, to 6/16 1944, and that I last saw her alive on 6/16 1944.

	Duration
Immediate cause of death: Card. Resp. failure	
Due to Uremia	5 days
Due to Senility, inanition	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby M.D.
Address Mercy Hosp. Date signed 6/16/44

C 18225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 18225 Registered No. 46 M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 N. Bentalou st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N. Bentalou st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter W. Price

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Bertha Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25. 1876

8. AGE: Years 68 | Months 11 | Days 16 | If less than one day hr. 21 min.

9. Birthplace Oak Island Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Severn Price
13. Birthplace Rock Creek, Md

MOTHER
14. Maiden Name Charlotte White
15. Birthplace Salisbury, Md

16 (a) Informant Mrs L. Albert Anderson
(b) Address 820 N. Bentalou st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory Rock Creek Cem
Location Rock Creek, Md

18 (a) Funeral director Howard A. Gill
(b) Address 1012 Overbrook Rd

19 (a) JUN 19 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16/44 19 , at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to 6/16/44 19 , and that I last saw him alive on 6/15/44 19 .

Immediate cause of death: Carcinoma of abdominal viscera — about 6 mo

Due to:

Due to: Incurable carcinoma of abdominal viscera — about 6 mo

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Walter S. Tebbett M. D.
Address 2220 Garrison Blvd Date signed May 17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18226

JO #88072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 18226 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 S. Ridgley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Flem Woody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Georgia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1899

8. AGE: Years 44 Months -7- Days -2- If less than one day hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jeff Woody
13. Birthplace Tenn.

MOTHER
14. Maiden Name Mollie Grubbs
15. Birthplace Tenn.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17 1944 (month) (day) (year)
(c) Cemetery or crematory Loved, Cemetery
Location Concord, Tenn.
Funeral director Frederick P. Cole
Address 1967 W. Lombard St.

18 JUN 19 1944
(Date rec'd by registrar) Registrar

19 (a)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1944, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944 to 6/17 1944 and that I last saw h[illegible] alive on 6/17 1944.

Immediate cause of death: Pulmonary TBC — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible] Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. I. Seigman M.D.

Address BCH Date signed 6/17

G 18227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18227 ✓ Registered No. 164 F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) 13
(d) Street No. NONE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Private Nicola Bastiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. UNKNOWN

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace NEW YORK (Town, county, and state)

10. Usual Occupation SOLDIER

11. Industry or business U.S. ARMY

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant U.S. Army
(b) Address CAMP HOLABIRD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 21/44 (month) (day) (year)
(c) Cemetery or crematory LONG ISLAND CEM.
Location LONG ISLAND CITY NEW YORK.

18 (a) Funeral director Lilly and Geiler INC
(b) Address 403 S. Wolfe St.

19 (a) JUN 18 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions Psychosis Neurosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: A
(a) Date of injury June 15, 1944 10:45 M.
(b) Where did injury occur? Annapolis Jct. B.&O.R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped from Train

23. Signature Albert O. Foster M.D.
Medical Examiner.

Date signed June 16, 1944

G 18228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18228 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 W. Henrietta
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Marion - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Horsey -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fem'l

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30 - 1875

8. AGE: Years 69 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Marion Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Bennie Horsley
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie Horsley
15. Birthplace Md.

16 (a) Informant Samuel Lewis
(b) Address 105 W. Henrietta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)

(c) Cemetery or crematory Waysmens Cem
Location Marion, Md.

18 (a) Funeral director Charles L. Law
Address 802 Madison Ave

19 (a) JUN 18 1944 (Date rec'd by registrar) (b) Registrar's signature

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1944, to June 17 1944 and that I last saw h[illegible] alive on June 17 1944.

Immediate cause of death Uraemia
Hy Pertension
Prostatectomy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 1720 L Sea Date signed 6/19/44

C 18229 C 18229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94 C 18229 C 18229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4226 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Miden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER 12. Name Isaac Greenberg
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Mrs Helen Stoller
(b) Address 4226 Park Heights ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Sterling Rem
Location Bonaly's Lane

18 (a) Funeral director Sol Levinson + Bro
(b) Address 1124-26 W North ave

19 (a) JUN 18 1944 (Date received by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1944, to 6/16 1944, and that I last saw her alive on 6/16 1944

Immediate cause of death: Pulmonary Edema — Duration 1 day
Due to Cardiac failure — ?
Due to Coronary Thrombosis — 5 weeks
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Taylor
Address W. B. & A. N. Date signed 6/16/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G 18230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Turkoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name Harry Turkoff
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Mrs Bessie Granai
(b) Address 941 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
Address 1124 1126 W North Ave

19 JUN 18 1944 (b) Hunt Brighton Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944, to June 17 1944, and that I last saw him alive on June 16 1944

Immediate cause of death	Duration
Cardiac failure	
Due to carcinoma of rectosigmoid	
Due to	
Other Conditions Generalized arteriosclerosis chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isadore Shonfeld M.D.
Address 601 N. Howard St Date signed 6/17/44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18231 — BALTIMORE CITY HEALTH DEPARTMENT — G 18231

CERTIFICATE OF DEATH 1106 C

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 Aisquith Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Aisquith Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Log Sacks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Horse

11. Industry or business

FATHER 12. Name Milton Sacks
13. Birthplace Russia

MOTHER 14. Maiden Name Annabelle
15. Birthplace Russia

16 (a) Informant Dr. Sacks
(b) Address University Hospt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Herzel Russian
Location Plot 96 Block 5 Section 4

18 (a) Funeral director Jos. Levi & Sons
(b) Address 1439 E. Baltimore St

19 (a) JUN 18 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to June 17 1944, and that I last saw h[illegible] alive on June 16 1944

Immediate cause of death: Aplastic Anemia — Duration 3 yr.

Due to ?

Due to

Other Conditions Bronchitis — 2 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton S. Sacks M.D.
Address University Hosp. Date signed 6/17/44

C 18232 | BALTIMORE CITY HEALTH DEPARTMENT | C 18232

CERTIFICATE OF DEATH

74B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Clarion
(c) City or town Ponufort
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Gore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married.

6 (b) Name of husband or wife Lenny Gore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1911

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Farming

FATHER
12. Name Charles Gore
13. Birthplace W. Va

MOTHER
14. Maiden Name Lena Davis
15. Birthplace W Va.

16 (a) Informant Hospital Records
(b) Address Maternity Hosp.

17 (a) Removal (b) Date thereof June 18 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Waldorf Md

18 (a) Funeral director Hunt & Ryon
(b) Address Waldorf Md

19 (a) 6-18-1944 (b) Huntington Williamsport, Md
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1944, at 10:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1944 to 6/17 1944, and that I last saw him alive on 6/17 1944.

Immediate cause of death	Duration
Acute Myelogenous Leukemia	2 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James S. Sherter M. D.
Address University Hosp Date signed 6/18/44

Please write the causes of death clearly and legibly. Physicians: please write the cause of death which is especially important. Do not use abbreviations or symbols. Please write the cause of death which is especially important. Physicians: please write the

G 18233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18233 (93) Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Monrovia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reese Mullinix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Mullinix

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 1, 1871

8. AGE: Years 73 | Months 0 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Montgomery County, Md. (Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business —

FATHER 12. Name Robert Mullinix

13. Birthplace Montgomery County, Md.

MOTHER 14. Maiden Name Julia (Mullinix)

15. Birthplace Montgomery County

16 (a) Informant Ella Mullinix

(b) Address Monrovia, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Brookville Md.
Location Montgomery Co. Md.

18 (a) Funeral director Roy W. Barber

(b) Address Laytonsville Md.

19 (a) ____ (Date rec'd by registrar) (b) JUN 19 1944

1944 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1944, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1944 to 6-18 1944, and that I last saw him alive on 6-18 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Hypertension C.V.D.	
Due to Marked Arteriosclerosis	
Other Conditions Uremia - B.P. Acute Urinary Retention	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Langman

Address University Hospital Date signed 6/18/44

Please write the causes of death clearly and legibly. Physicians: please report any correct age is especially important.

G 18234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18234
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Samuel Howard

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: B
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): ? 1899

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Sam. Howard.
(b) Address

17 (a) Burial (b) Date thereof 6-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location New Windsor, Md

18 (a) Funeral director Raymond R. Wright
(b) Address Union Bridge. Md.

(a) (b) Registrar

JUN 18 1944 Westminster, Md.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944 to June 15 1944, and that I last saw him alive on June 15 1944

Immediate cause of death: Bulbar palsy

Due to: CVS Acc.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature LeRoy W Tull M. D.
Address Univ. Hosp Date signed 6-17-44

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G 18235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G 18235 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 Otterbein St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 314 Otterbein St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Ross

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1892

8. AGE: Years	Months	Days	If less than one day
52	1	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John J. Miller
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Mary E. Brown
15. Birthplace Balto. Md

16 (a) Informant Blanche Brown
(b) Address 814 Vine St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn St
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Signature of registrar) (b) Registrar

JUN 18 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16/44 19 , at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944 to 6/16 1944, and that I last saw h alive on 6/15 1944.

Immediate cause of death	Duration
Arteriosclerosis Gen	
Acute Gastro Enteritis	
Due to Hemiplegia	4wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Blackson

Address 604 Arlington Ave Date signed 6/17/44

Hunterdon Pittsville, Md

G 18236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18236 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland - D.O.A.
(b) Street address 2807 Elsinor Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Elsinor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva S. Ritchie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband ~~or wife~~ John M. Ritchie Jr.
Lt. Col. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 - 1881

8. AGE: Years	Months	Days	If less than one day
62	6	29	hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name William F. Senior
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Sarah Howe
15. Birthplace Phila. Pa.

16 (a) Informant John M. Ritchie Jr.
(b) Address 2807 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 1944 (month) (day) (year)
(c) Cemetery or crematory Arlington National Cem.
Location Virginia

18 (a) Funeral director Frankie Cook Dyer
(b) Address 1600 W. North Ave

JUN 18 1944
(Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 1:40 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertension and Arteriosclerotic C.V. disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Walter J. Sulinski M.D.
Medical Examiner,
Date signed 6/12/44

C 18237

AB-87178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

C 18237

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. File correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.,

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.-18days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 831 N. Eutaw St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. Hetlick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William A. Hetlick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1- 1863

8. AGE: Years	Months	Days	If less than one day
80	10	15	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name Robert Phillip

13. Birthplace Md.

MOTHER

14. Maiden Name Mery E.

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19 44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Co.

Location Greenmount Ave & Oliver Sts

18 (a) Funeral director Geo. J. Ruth Inc. 6 E. M.

(b) Address 1735 Harford Ave

JUN 18 1944 (b) Baltimore, Md.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16- 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 19 44 to June 16 1944, and that I last saw h.e alive on June 15 19 44.

Immediate cause of death Pneumonia — Duration 7

Due to Arteriosclerotic Gangrene — Duration ??

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jos. G. Bourgeois M. D.

Address Baltimore City Hosp. Date signed June 17 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4551 18238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

C 18238 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Mc Culloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hezzie

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 8-26-92

8. AGE: Years 51 52 | Months 9 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER — 12. Name Robert Dorsey; 13. Birthplace Md

MOTHER — 14. Maiden Name Caroline Kenard; 15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof Jun. 17-44 (month) (day) (year)
(c) Cemetery or crematory Lakeview Memorial Pk.
Location Balto. Md.

18 (a) Funeral director Archibald A. Geddes
(b) Address 2101 Mc Culloh St. Balto.

JUN 18 1944 (Date received by registrar) (b) Registrar
Huntingtown Prince Georges, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 930 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 15 1944, and that I last saw her alive on June 15 1944.

Immediate cause of death: Diabetic coma — Duration
Due to: occlusion left femoral artery — Duration
Due to: ? cerebral accident — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature John R. Cunningham M.D.
Address JHH Date signed 6-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G-18239 18239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1871

8. AGE: Years 62 | Months 4 | Days 11 | If less than one day hr. min. 8 2

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business

FATHER
12. Name Joseph Dorsey
13. Birthplace Md Va

MOTHER
14. Maiden Name Martha Green
15. Birthplace Va

16 (a) Informant Millard A. Dorsey
(b) Address 719 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director Wm. Geo. H. Wolfolk
(b) Address 1631 Druid Hill Ave.

19 JUN 19 1944 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1944 at 10:03 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to June 13 1944, and that I last saw him alive on June 13 1944.

Immediate cause of death Pneumonia 4 days

Due to

Due to

Other Conditions Renal Insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. G. Bayne M. D.
Address Provident Hospital Date signed 6/19/1944

VS 150

G 18240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G 18240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Eutaw Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham [illegible] Lerisky

3 (b) If veteran, name war

3 (c) Social Security Account No. 066-14-3847

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh.	Married

6 (b) Name of husband or wife Shirley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Brooklyn N.Y. (town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Shirley Lerisky.
(b) Address New York N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/44 (month) (day) (year)
(c) Cemetery or crematory Gem.
Location New York N.Y.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1454 E Balto. St

(b) Date received JUN 19 1944 (Registrar) (b) Hunter's Point Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18/1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18/1944 to 6/17/1944, and that I last saw h[illegible] alive on 6/17/1944

Immediate cause of death Cardiac failure

Due to Myocardial infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 6/18/44

18241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

XV 117b

G 18241 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Fenlon Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Hammonds Ferry Rd #27 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Miller

3 (b) If veteran, name war: 10

3 (c) Social Security Account No. 218-14-6793

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Annie Amelia Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1894

8. AGE: Years 49 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Austria-Hungary (Town, county, and state)

10. Usual Occupation Tool Maker

11. Industry or business Bethlehem-Fairfield Corp.

FATHER
12. Name Milan Miller
13. Birthplace Austria-Hungary

MOTHER
14. Maiden Name Verna (Unknown)
15. Birthplace Austria-Hungary

16 (a) Informant Annie Miller
(b) Address 1900 Hammonds Ferry Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JUN 19 1944 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1944, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1944 to 6-16 1944, and that I last saw ~~him~~ alive on 6-16 1944.

Immediate cause of death	Duration
Perforated duodenal ulcer; b subdiaphragmatic	
Due to abscess and empyema right chest	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-4-44

Major findings of operation: Perforated ulcer

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address [illegible] Date signed 6-16-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18223488

BALTIMORE CITY HEALTH DEPARTMENT V G 18242

CERTIFICATE OF DEATH 137a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mexico (b) County City
(c) City or town Mexico
(If outside city or town limits, write RURAL and give town)
(d) Street No. Begonia #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hogarth

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. none
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Sophia Knipe
6 (c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) 12-23-73
8. AGE: Years 70 | Months 5 | Days 24 | If less than one day hr. min.
9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Industrialist
11. Industry or business

FATHER
12. Name Joseph Hogarth
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Pirie
15. Birthplace Scotland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6/19/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 JUN 19 1944 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17- 1944, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1944, to 6-17- 1944, and that I last saw h[illegible] alive on 6-17- 1944

Immediate cause of death: Cerebral thrombosis — Duration: 3 days
Due to: Arteriosclerosis
Due to:
Other Conditions: Post-operative perineal prostatectomy
(Include pregnancy within 3 months of death)
Date of operation 6-12-44
Major findings of operation: Benign Prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell R. Boots M.D.
Address Johns Hopkins Hosp. Date signed 6/17/44

G 18243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G 18243 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F Loane

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ethel Edna Loane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1891

8. AGE: Years 52 Months 10 Days 3 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business E McDermott

FATHER
12. Name Augustus Loane
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary E Tilghman
15. Birthplace Baltimore Md

16 (a) Informant Ethel E Loane
(b) Address 414 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore Md

18 (a) Funeral director Wm J Ford
(b) Address

JUN 19 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Nils P Sulzbacher M.D. Medical Examiner.
Date signed 6/17/44

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18244 ✓ G 18244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: St. Joseph's
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2547 Robb st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Velma Haas

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ John Haas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24th 1872

8. AGE: Years	Months	Days	If less than one day
71	11	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

MOTHER / FATHER

12. Name Unknown

13. Birthplace Germany

14. Maiden Name "

15. Birthplace "

16 (a) Informant John Haas

(b) Address 2547 Robb st.

17 (a) Burial (b) Date thereof 6/20/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

JUN 19 1944 (Date rec'd by registrar) Huntingdon Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1944, to 6/18 1944, and that I last saw h.e.r. alive on 6/18 1944.

Immediate cause of death	Duration
Uremia	
Due to Chronic Glomerular Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Wadsworth

Address 1400 N. Caroline Date signed 6/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

18245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. C 18245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hosp. Catonsville
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3134 Stafford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil J. Marsh.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-4-1944.

8. AGE: Years | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Le Roy Thomas Marsh.
13. Birthplace Md.

MOTHER
14. Maiden Name Sadie Beadenkopf
15. Birthplace Md.

16 (a) Informant Mother. Sadie Marsh.
(b) Address 3134 Stafford St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof June-19-44. (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab.
(b) 5 N. Monroe St. Huntingdon Williamsport, Md.

JUN 19 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1944 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1944 to 6/17 1944 and that I last saw h[illegible] alive on 6/17 1944

Immediate cause of death: Infectious Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature F. L. Kaffuce-Ace M. D.
Address Sagner Date signed 6/17/44

VS-150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

6-18246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 53

Registered No. C 18246

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital. 15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3821 Hamilton ave., Balt. Md. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Contos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1874

8. AGE: Years	Months	Days	If less than one day
69	11	14	hr. min.

9. Birthplace Greece (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER | FATHER

12. Name James Contos

13. Birthplace Greece

14. Maiden Name Betty Patzolakis

15. Birthplace Greece

16 (a) Informant Robert Contos

(b) Address 3821 Hamilton ave Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19, 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn.

Location

18 (a) Funeral director S. Kanavos & Son

(b) Address 345-47 Chestnut Ave

(c) Filed JUN 19 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1944 to June 17 1944 and that I last saw him alive on June 17 1944

Immediate cause of death Respiratory Failure — Duration 5 hrs.

Due to Generalized Toxemia

Due to Pemphigus — Duration 2 yrs. 8 m.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul R. Ziegler, M. D.

Address Mercy Hosp. Date signed 6-17-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The G

18247
5712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

Registered No. G 18247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Bk

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-90

8. AGE: Years 53 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Factory Worker

11. Industry or business Metal Specialty Co.

FATHER 12. Name George Williams (Md)

13. Birthplace Africa (Md)

MOTHER 14. Maiden Name Molina

15. Birthplace (Md)

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-44 (month) (day) (year)

(c) Cemetery or crematory Md. Calvary

Location A. L. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.

(b) Address 1171 W. Carrollton Ave

JUN 19 1944

(a) Registrar (b) Thos. Augustus Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 - 1944 at 3.03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12-1944 to 6-16-1944 and that I last saw her alive on 6-16-1944

Immediate cause of death Pneumonia — Duration 2 weeks

Due to ?

Due to ?

Other Conditions Uremia — ? weeks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Augustus Williams M.D.

Address Johns Hopkins Date signed 6/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18248
TM. 87969

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

58d

G 18248
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-month & 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Twarek Jr.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8th, 1932

8. AGE: Years 11 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Joseph Twarek Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Kuchta (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 20/44 (month) (day) (year)
(c) Cemetery or crematory HOLT ROSARY
Location GERMAN HILL ROAD

18 (a) Funeral director Lillyard Qeeley & Co.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) (b) Registrar

JUN 19 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1944, at 8.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944, to 6-15 1944, and that I last saw him alive on 6-15 1944

Immediate cause of death ? Embolus from Heart — Duration 1 sec

Due to Rheumatic Heart disease — Duration 4 yrs

Due to Rheumatic fever — Duration 4 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Dave Mattern M.D.
Address B.C.H. Date signed 6/15/44

G 18249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18249 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Hilton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Brookland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella May Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles W. Young

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Oct 31 1863

8. AGE: Years 80 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace W. Virginia (town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Joseph H. Dunger
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Julia Argabrite
15. Birthplace W. Virginia

16 (a) Informant Charles Watson Young
(b) Address 2705 Woodsdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1944 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Harry W. Amacher
(b) Address 4th & Belgium Ave

19 (a) JUN 19 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1944 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17, 1944 to June 18, 1944 and that I last saw h. alive on June 18, 1944

Immediate cause of death: Myocardial insufficiency — Duration: 2 days

Due to: Arteriosclerosis & Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney L. Levy M. D.

Address 2322 Eastern Pkwy Date signed 6/19/44

VS 150

G 18250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G 18250

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St

(c) Hospital or institution: Bon Secours Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs. 55 min

(e) Length of stay in Baltimore (yrs., mos., or days) 7 hrs. 55 min

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 7

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3715 Gwynn Oak Ave

(If rural give location).

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary F. Carew Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-44-9 05 pm

8. AGE: Years	Months	Days	If less than one day
			7 hr.s 55 min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Filmore Hess

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Margaret Theresa Parker

15. Birthplace Baltimore Md.

16 (a) Informant Jesse E Parker

(b) Address 3715 Gwynn Oak Ave

17 (a) Burial (b) Date thereof June 19 1944

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director Harry A. Arnaud

(b) Address 4704 Reisterstown Ave

JUN 19 1944 (b) Thomas F. Williams M.D.

(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1944, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1944 to 6-18 1944, and that I last saw her alive on 6-18 1944

Immediate cause of death Cerebral Hemorrhage — Duration 7 hr. 55 m.

Due to Prematurity

Due to

Other Conditions Convulsions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Chas Norton Jr. M.D.

Address Bon Secours Hosp. Date signed 6/18/44

18251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 18251

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Union Mem. Hosp.

(c) Hospital or institution: 3rd & Calvert St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2908 Southern Ave. - 14

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country No.

3 (a) FULL NAME ANNIE T Mrs. Raymond A. Hennessey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M

6 (b) Name of husband or wife Raymond P. Hennessey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/1884

8. AGE: Years	Months	Days	If less than one day
59	5	18	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business —

FATHER

12. Name Joseph Real

13. Birthplace Baltimore.

MOTHER

14. Maiden Name Elizabeth Slaughter.

15. Birthplace Baltimore, Md.

16 (a) Informant self

(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director Leonard Flinch

(b) Address 5305 Harford Rd

19 (a) JUN 19 1944 Registrar Thomas L. Chipfelle M.D. Address Union Mem. Hosp. Date signed 6/17/44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944 to 6/17 1944, and that I last saw her alive on 6/17 1944.

Immediate cause of death Cardiac decompensation

Due to coronary sclerosis.

Due to arteriosclerosis

Other Conditions mild diabetes

(Include pregnancy within 3 months of death)

Date of operation 6/16/44.

Major findings of operation: amputation of Rt. leg.

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas L. Chipfelle M. D.

G 18252 ✓ G 18252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline & P. St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Glenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pearl Butts (Butts)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Leonard F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1903

8. AGE: Years	Months	Days	If less than one day
41		4	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Patrick J. Thornton
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine McGee
15. Birthplace Ireland

16 (a) Informant Mrs Agnes R. Chenowith
(b) Address 5310 Terrace Rd

17 (a) Cremation
(Burial, cremation, or removal)
(b) Date thereof 6-21-44
(month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director Leonard Hunt
(b) Address 5245 Harford Rd

19 (a) (Date rec'd by registrar) (b)

JUN 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1944 to 6/17 1944, and that I last saw her alive on 6/17 1944

Immediate cause of death Cerebral Vascular Accident

Due to Hypertension

Due to Cerebro-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Waldron M.D.

Address 1400 N. Caroline Date signed 6/17/44

M. D. B. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18253

CERTIFICATE OF DEATH

8 30 G 18253

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Wolfe St St., 1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME C. Bascom Faulkner

(a) Residence: No. 525 N. Wolfe St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ellen

6. DATE OF BIRTH (month, day, year): 2/12/1887

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
57	4	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Real Estate Owner

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Balto. Md

FATHER

13. NAME: Eldridge R. Faulkner

14. BIRTHPLACE (city or town) (State or country): Md

MOTHER

15. MAIDEN NAME: Sarah E. Jefferson

16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT: Mrs. Mary Ellen Faulkner
(Address): 525 N. Wolfe St.

18. BURIAL, CREMATION, OR REMOVAL
Place: Lorraine Park Date: 6/19/44 19...

19. UNDERTAKER: R. J. Black
(Address): 5805 Harford Rd.

20. JUN 19 1944 19... Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): June 15th 1944

22. I HEREBY CERTIFY, That I attended deceased from June 11th 1944 to June 15th 1944

I last saw him alive on June 5th 1944 Death is said to have occurred on the date stated above, at 10:30 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Hemorrhage	4 hours

Other contributory causes of importance:

arteriosclerosis	one year
H pulmonum	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
... If so, specify ...

(Signed) H. J. Lankford M. D.

(Address) 160 N. Milton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 18254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 18254
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. of A.
(b) Street address 1620 N. Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Pratt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Joseph Pratt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) march 20, 1902

8. AGE: Years 42 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name — Abrams
13. Birthplace md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Joseph Pratt
(b) Address 1620 n. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory mt Auburn
Location md

18 (a) Funeral director George H. Kelson
(b) Address 1203 Presstman St

19 (a) (b)
(Signature) (Address) Registrar

JUN 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Examination and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Breast
& Metastasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 6/17/44

G 18255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 18255

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County.....
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Unidentified Colored Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 9 | Months: | Days: | If less than one day: .....hr. .....min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location.....

18 (a) Funeral director George E. Kelson
(b) Address 1303 Presstman St

19 (a) AUG 1 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1944, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Found drowned

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur? Jones's Falls & 30th St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Found drowned

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed July 31 1944

G 18256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18256

83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BRANCH

3 (b) If veteran, name war —

3 (c) Social Security Account No. 242-12-0989

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida Branch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 15, 1870

8. AGE: Years 73 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Silons Branch
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Ida Branch
(b) Address 1514 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-44 (month) (day) (year)
(c) Cemetery or crematory Arlington cem.
Location Md

18 (a) Funeral director George S. Nelson
(b) Address 1302 Pennsylvania Ave

19 (a) JUN 19 1944 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. F. Wallenmeier M.D. Medical Examiner.
Date signed June 17, 1944.

VS 151

G 18257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170C

Registered No. G 18257

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 N. Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ivy Stark

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or ~~wife~~ Belle

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1871

8. AGE: Years	Months	Days	If less than one day
72	9	25	hr. min.

9. Birthplace New York. N.Y.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Shippen Stark
13. Birthplace Rukersown.

MOTHER
14. Maiden Name Harriett Leatt
15. Birthplace Va

16 (a) Informant Hattie R. Holmes (Sister)
(b) Address 2037 N. Hoffman St

17 (a) Burial (b) Date thereof 6/19/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Caroline St.

19 (a) JUN 19 1944 Baltimore, Md.
(Registrar's signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comminuted Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury June 11 1944 at 10:15 P.M.
(b) Where did injury occur? Gilmor & Mosher Sts
Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Ed Gratam M.D.
Medical Examiner
Date signed June 16 1944

C 18258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

C 18258 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Maude Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Albert Jones
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1878

8. AGE: Years	Months	Days	If less than one day
65	8	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Ezekeil Neighoff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maggie M.
15. Birthplace

16 (a) Informant Mr. Albert Jones
(b) Address 16 N. Pulaski St.

17 (a) Burial (b) Date thereof June 19, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Frederick, A. Cole
(b) Address 1200 W. Lombard St.

JUN 19 1944 (b) Hunter Williams, M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1943 to June 16 1944
and that I last saw h[illegible] alive on June 6 1944

Immediate cause of death	Duration
Coronary Thrombosis	18 mos.
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Thornhill M. D.
Address 2302 Edmondson Ave Date signed 6/19/44

G 18259 BALTIMORE CITY HEALTH DEPARTMENT G 18259
CERTIFICATE OF DEATH 108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. High
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 107 N. High St. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Eva Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female 5. Color or race Col
6 (a) Single, married, widowed, or divorced. Married 2/14/1942
6 (b) Name of husband or wife Frank Kelly
6 (c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) 1910
8. AGE: Years 34 Months Days If less than one day hr. min.
9. Birthplace Norfolk, Va (Town, county, and state)
10. Usual Occupation Wife
11. Industry or business
FATHER 12. Name Semmes Williams
13. Birthplace Va
MOTHER 14. Maiden Name Martha Swanton
15. Birthplace Va
16 (a) Informant Frank Kelly
(b) Address 107 N High
17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof June 17 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Md
18 (a) Funeral director Robert E. Wilkins
(b) Address 1515 McElderry St
19 (a) (Date received by Registrar) JUN 19 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944 at 645 AM
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 15 1944 and that I last saw deceased alive on June 5 1944
Immediate cause of death Acute Lobar Pneumonia — Duration 15 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo. L. Allen M. D.
Address 121 Chesapeake St Date signed June 19 44

G 18260 F 91662 83a G 18260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rockwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME (Purnell) Baby Boy Dooley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Baby.

6 (b) Name of husband or wife — Baby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-17-1943

8. AGE: Years	Months	Days	If less than one day
	5	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Baby -
11. Industry or business

FATHER 12. Name Rev. E. A. Dooley
13. Birthplace Penn.

MOTHER 14. Maiden Name Alice Gilbert
15. Birthplace md.

16 (a) Informant Father.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A a Co.

18 (a) Funeral director Robert E. Jennings
(b) Address 1501 madison ave

19 (a) (b) Baltimore Md. Registrar

JUN 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to June 16 1944, and that I last saw him alive on June 16 1944.

Immediate cause of death	Duration
Atelectasis	
Due to ? Prematurity	
Due to	
Other Conditions Abd Cerebral Accident	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Gubleman M. D.
Address University Hospital Date signed June 17, 1944

G 18261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1466

G 18261 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 N. Kresson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul J Dorbit

3 (b) If veteran, name war —

3 (c) Social Security Account No. 196-05-5026

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Teresa M. Dorbit

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1881

8. AGE: Years: 63 | Months: 3 | Days: 10 | If less than one day: min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Henry Dorbit
13. Birthplace: Germany

MOTHER
14. Maiden Name: Agnes —
15. Birthplace: Germany

16 (a) Informant: Mrs Teresa M. Dorbit
(b) Address: 33 N. Kresson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem
Location: Baltimore

18 (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Eastern Ave

19 (a) (Date received by registrar) (b) Registrar

JUN 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1944 at 1928 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1944 to 6-16 1944 and that I last saw h[im] alive on 6-16 1944.

Immediate cause of death: Acute myocardial failure — Duration: 24 hrs

Due to: Arteriosclerosis

Due to:

Other Conditions: Coronoma of stomach (Include pregnancy within 3 months of death)

Date of operation 6-15-44

Major findings of operation: extensive carcinoma of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Stanley B. Klymowicz
Address: St Joseph's Hosp Date signed 6-17-44

Thurlow Williams, M.D.

G 18262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1944

G 18262 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4616 Kavon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry D. Mueller

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-4496

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1891

8. AGE: Years	Months	Days	If less than one day
53	2	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business American Railway

FATHER
12. Name Robert Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary E. Mueller
(b) Address 4616 Kavon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 21 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 1921 Orleans St.

JUN 19 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 5 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester R. Tabacinski M.D.
Medical Examiner.
Date signed 6/19/44

18263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944 Registered No. 18263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Cathedral st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Cathedral st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Harry Fielding Reid

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of ~~husband~~ or wife: Edith Gittings Reid
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 18th 1859
8. AGE: Years 85 | Months 1 | Days 0 | If less than one day: hr. min.
9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual Occupation: Prof. Medicus
11. Industry or business: Johns Hopkins

FATHER
12. Name: Andrew Reid
13. Birthplace: Unknown

MOTHER
14. Maiden name: Fannie B. Guathney
15. Birthplace: Va.

16 (a) Informant: Doris F. Reid
(b) Address: 608 Cathedral st.

17 (a) Burial, ~~cremation, or removal~~ (b) Date thereof: 6/21/44
(month) (day) (year)
(c) Cemetery ~~or crematory~~: Green Mount
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st.

JUN 19 1944
(Date rec'd by) (b) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1944, at 5.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to June 18 1944, and that I last saw ~~him~~ alive on 6/18 1944

	Duration
Immediate cause of death: Arterio-Sclerosis Myocarditis	Terminal
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: W H Moody M.D.
Address: 1403 Park Ave Date signed: 6/19/44

G 18264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G 18264

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Same as address
(a) State Md. (b) County Baltimore
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 10th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Furman F. Duckett

3 (b) If veteran, name war

3 (c) Social Security Account No. 237-34-9410

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28-1888

8. AGE: Years 55 | Months 5 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Buncombe, N. C.
(Town, county, and state)

10. Usual Occupation Loaderer

11. Industry or business Western Elec. Co.

FATHER
12. Name Robt. Lee Duckett
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace N. C.

16 (a) Informant Glenn Duckett
(b) Address 3904-10th St. Brooklyn, Md.

17 (a) Removal (b) Date thereof 6-20-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Jarretts
Location West Ashville, N.C.

18 (a) Funeral director Wm Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) JUN 19 1944 (Date rec'd by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1944, at 11 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease.

Due to:

Other Conditions Chronic myocarditis Edema & congestion of lungs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed June 19 1944

C 18265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 a

C 18265

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Blvd. Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Bretton Place
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME M. Josephine Daily (M. Josephine Daily)

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 72	--	--	-- hr. -- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Thomas Daily
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Gotterfield
15. Birthplace Maryland

16 (a) Informant Mrs. Isaac S. George
(b) Address 406 Bretton Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery ######## New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meara & Sons
(b) Address 805 N. Calvert St.
(a) [illegible] (b) [illegible] M.D.
(Registrar)

JUN 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to June 17 1944, and that I last saw h.. alive on June 17 1944.

Immediate cause of death	Duration
Due to Chr. Myocarditis	1942
Due to Chr. Interstitial Nephritis	1942
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1636 Nash St. Date signed 6/19/44

C 18266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 18266

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 Madison Ave.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 61 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Patrick Sherry

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ wife: Caroline Collier
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years: About 76 | Months: --- | Days: --- | If less than one day: --- hr. --- min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation: Plumber
11. Industry or business: ----------

FATHER
12. Name: Hugh Sherry
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Bridget ?
15. Birthplace: Ireland

16 (a) Informant: Mrs. Karl Hanselmann
(b) Address: 1800 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery ~~Green Mount~~ Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Meuse & Son
(b) Address: 805 N. Calvert St.

19 (a) 6/19/44 by registrar Hunter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944 at 3:19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 43 to 6/18 19 44, and that I last saw h~~im~~ alive on 6/18 19 44

Immediate cause of death: Cancer of Stomach — Duration: 6 mo

Due to: ----------

Due to: ----------

Other Conditions: X-ray findings

(Include pregnancy within 3 months of death)

Date of operation: ----------

Major findings of operation: ----------

of autopsy: ----------

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----------
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? ---------- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ----------
(Specify)
(e) Means of injury ----------

23. Signature: Louis Wolff M. D.
Address 2020 E. Chase Date signed 6/19/44

G 18267

HEALTH DEPARTMENT—CITY OF BALTIMORE B 18267

CERTIFICATE OF DEATH.

131a

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 514 E. 41st ST., (Ward) 9-1

2-FULL NAME Emma Alice Hayden

(a) RESIDENCE NO. 514 E. 41st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A. Hayden
6 DATE OF BIRTH (month, day, and year): Jan 18-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS
10 NAME OF FATHER: Charles Teel
11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania
12 MAIDEN NAME OF MOTHER: Elizabeth Ackerman
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Charles A. Teel 514 E. 41st Street

15 Filed ..... 19 Huntington Williams, M.D.

JUN 19 1944

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19th 1944

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1944 to June 19th 1944
that I last saw h-d alive on June 19th 1944
and that death occurred, on the date stated above, at 9.14 A m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterial Deterioration. Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) B. A. Liberson, M. D.
6/19, 19 44 (Address) 36 N Fulton Ave. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Plainfield Cem. Pennsylvania — DATE OF BURIAL: June 19 1944
20 UNDERTAKER: Burgee Funeral Home — ADDRESS: 623 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

792007 G 18268

G 18268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Womens Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME General Quinco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-1943

8. AGE: Years | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name General Quince
13. Birthplace D.C.

MOTHER: 14. Maiden Name Irene Queen
15. Birthplace Md.

16 (a) Informant Clifton Queen
(b) Address 707 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel Co. Md.

18 (a) Funeral director Mrs. Frances A. Hemphill
(b) Address 571 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 17 1944 and that I last saw him alive on June 17 1944

Immediate cause of death: Bronchopneumonia — Duration: 6 weeks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Womens Hospital Date signed 6/18/44

C 18269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No. C 18269

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 W. Camden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days) Y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 W. Camden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter J. Bludzuns

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Bludzuns

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years About 58 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ? Bludzuns
13. Birthplace Lithuania

MOTHER 14. Maiden Name Not Known
15. Birthplace Lithuania

16 (a) Informant Mrs. Mary Bludzuns
(b) Address 426 W. Camden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director Jos. L. Grebliauskas, Jr.
(b) Address 425 S. Paca St.

19 (a) (b) Huntington Woods, Md.

JUN 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 4:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1943 to 6/17 1944 and that I last saw h[illegible] alive on 6/17 1944

Immediate cause of death Acute Cardiac Failure — Duration 1 hr

Due to Cardiovascular Renal — 5 Yr

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Dorothy Lou Carter M. D.
Address 4 Washington Blvd Date signed 6/19/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~18270~~ 944a

Registered No. G 18270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Key Highway
(c) Hospital or institution: Bethlehem Fairfield Shipyards

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 16 E. Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Ernest Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-4790

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1885

8. AGE: Years	Months	Days	If less than one day
58	8	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Foreman for H.E. Cook

11. Industry or business

FATHER 12. Name Arthur Gregory

13. Birthplace Md

MOTHER 14. Maiden Name Eliza Glass

15. Birthplace Md

16 (a) Informant Mrs Minnie C Gregory

(b) Address 16 E Montgomery

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location 2930 Frederick Ave

18 (a) Funeral director William M Mareck

(b) Address 715 Light St

JUN 19 1944 (Date received by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944, at 8:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollammeher M.D. Medical Examiner.

Date signed June 17, 1944.

VS 161

C 18271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47d

C 18271 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E Hill at
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 E. Hill St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carol Rolland

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-3041

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1897

8. AGE: Years	Months	Days	If less than one day
57	4	2	hr. min.

9. Birthplace Norfolk Va (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER 12. Name Joseph A Rolland
13. Birthplace Va

MOTHER 14. Maiden Name Sarah E Hitchens
15. Birthplace Va

16 (a) Informant Mrs Ethel Rolland
(b) Address 6 E Hill st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3800 Frederick Ave

18 (a) Funeral director William M Mareck
(b) Address 715 Light St

JUN 19 1944 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944, at 10 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to June 16 1944, and that I last saw him alive on June 16 1944.

Immediate cause of death: Carcinoma Pulmonary. — Duration: 4 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature O B Whitelo MD
Address 1279 Fulham M Date signed 6/19/44 M. D.

G 18272

JO #87548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 18272 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 562
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-8568

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1893

8. AGE: Years	Months	Days	If less than one day
50	-6-	27	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Robinson (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Caroline Gaskins
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie B Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)

JUN 19 1944

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944 to June 13 1944, and that I last saw h[illegible] alive on June 12 1944

Immediate cause of death: Carcinoma of penis with metastases — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. E. Sheppard M. D.
Address Balto City Hosp. Date signed June 13 1944

G 18273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59B

G 18273 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Orchard

(b) Street address 531 Orchard St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Va. (b) County Roanoke

(c) City or town Roanoke (If outside city or town limits, write RURAL and give town)

(d) Street No. 718 Park Ave. S.W. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Fannie Spencer (SPENCER)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/1890

8. AGE: Years 54 Months 1 Days 28 If less than one day hr. min.

9. Birthplace Roanoke Va. (Town or county) (State or foreign country)

10. Usual Occupation Domestic

11. Industry or business —

FATHER 12. Name James Thompson

13. Birthplace Va

MOTHER 14. Maiden name Adelia Brockett

15. Birthplace Va

16 (a) Informant Fannie Spencer

(b) Address 531 Orchard St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 6-20-44 (month) (day) (year)

(c) Cemetery or crematory Roanoke Cem

Location Roanoke Virginia

18 (a) Funeral director William C. Jackson

(b) Address 916 Penna Ave

19 (a) [illegible] June 19 1944 Health Officer

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/44 1944 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/44 to 6/17/44, and that I last saw h[illegible] alive on 6/17/44

Immediate cause of death: Contraction of the bowels Due to Cirrhosis of Liver Duration 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Lee Sloan M. D.

Address 1st Nat Bk Date signed 6/19/44

G 18274.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 18274 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 666 Sarah Ann
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 4
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 666 Sarah Ann
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Catherine Leaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) — — 1873

8. AGE: Years 71 | Months — | Days — | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Joe Hicks
13. Birthplace Va.

MOTHER
14. Maiden Name Emma ?
15. Birthplace Va

16 (a) Informant Rosa Grasty
(b) Address 666 Sarah Ann St

17 (a) Burial (b) Date thereof 6-20-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wilson A Jackson
(b) Address 966 Pennsylvania ave

19 (a) ..... (b) .....
(Date rec'd by registrar)

JUN 19 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 44 to June 17 1944 and that I last saw h... alive on ..... 19....

Immediate cause of death Bronchopneumonia of Brain — Duration .....

Due to ..... — .....

Due to ..... — .....

Other Conditions ..... — .....

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Frank E Wagner
Address 3027 Calvert St Date signed 6/19/44

G 18275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G 18275 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy Agnes Rehbein (Mrs.)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Charles Rehbein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1892

8. AGE: Years 52 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Herman E. Graefe
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address Women's Hosp. Johns & Lafayette Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 '44 (month) (day) (year)
(c) Cemetery or cemetary Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Harry A. Wilkie
(b) Address 4616 Edmondson Ave

19 (a) JUN 19 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 10 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to June 18 1944, and that I last saw her alive on June 18 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Post-Operative Bronchopneumonia	3 da
Due to Status Asthmaticus	2 yrs. 6 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 16, 1944
Major findings of operation: Denervation R. bronchi, bilateral
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. McCosh M. D.
Address Women's Hospital Date signed 6/18/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 3

G 18278 — G 18276

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Patricia Ann Ziegler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1943

8. AGE: Years 0 | Months 6 | Days 19 | If less than one day hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Dr. Paul R. Ziegler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Miss Margaret Butler
15. Birthplace Baltimore

16 (a) Informant Dr. Paul R. Ziegler
(b) Address 521 Mt Holly St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6-21-44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Howland Ave Cath

18 (a) Funeral director H. H. Wirth
(b) Address 4104 Edmondson Ave Cath

19 (a) (Signature) (b) Registrar (Registered by registrar)

VS III 19 1944 Huntington Publishing Co., Balto., Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944, to June 19 1944, and that I last saw her alive on June 19 1944.

	Duration
Immediate cause of death Respiratory Failure	—
Due to Lobar pneumania - left lung.	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Ellsworth Cook Jr. M. D.
Address Mercy Hospital Date signed June 19 '44

G 18279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 18277 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address North Broadway

(c) Hospital or institution:

Church Home & Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 215 days

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1507 Aisquith St.

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Annetta Mann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ?

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-5-87

8. AGE: Years	Months	Days	If less than one day
56 57	6	12	..... hr. ..... min.

9. Birthplace Leavenworth, Kans.

(Town, county, and state)

10. Usual Occupation School-teacher

11. Industry or business

FATHER 12. Name Nathan A. Mann

13. Birthplace Center Village, Ohio

MOTHER 14. Maiden Name Charlotte L. Short

15. Birthplace Springfield, Illinois

16 (a) Informant Hosp. Record

(b) Address

17 (a) Burial (b) Date thereof June 21 44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Henry W. Jenkins & Son

(b) Address McCulloh & Orchard Sts.

19 (a) JUN 19 1944 (b) Registrar

(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1944, at 10:37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1943, to 6-17-1944, and that I last saw h~~e~~r alive on 6-17 1944.

Immediate cause of death	Duration
Tuberculosis of Larynx	
Due to Ca of breast	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Charles Steven Hatch M. D.

Address C.H.H. Date signed 6-18-44

G 18278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18278 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 2413
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Riverside Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jeffers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6, 1883

8. AGE: Years	Months	Days	If less than one day
60	7	10	hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Jeffers
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Boyle
15. Birthplace Ireland

16 (a) Informant Madeline Jeffers.
(b) Address 2939 Elliott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) 6/21/44 (Date received by registrar) [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1944, at 11:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1944 to June 16 19 44, and that I last saw her alive on June 16 19 44.

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis — 8 days

occurred following Operation

Due to Hypertensive Cardio Vascular disease — years

Other Conditions Hematuria on basis not determined during hospitalization

(Include pregnancy within 3 months of death)

Date of operation June 8th 1944

Major findings of operation: Exploratory Laparotomy, Cholecystectomy, Negative

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Patrick C. Shelan M. D.

Address Mercy Hospital Date signed 6/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

323477
18279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G 18279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Caroline
(c) City or town Greensboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Walls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-29

8. AGE: Years	Months	Days	If less than one day
14	8	8	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Clifton Walls
13. Birthplace ?

MOTHER
14. Maiden Name Myrtle Thompson
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)

(c) Cemetery or crematory Greensboro
Location Greensboro Md.

18 (a) Funeral director R. B. Rawlings
(b) Address Greensboro Md

19 JUN 20 1944 (Date received by Registrar) (Signature of Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944 to June 19 1944 and that I last saw her alive on June 19 1944

Immediate cause of death	Pneumonia, R&L Lg	Duration
Due to	Aplastic Anemia	
	Cause unknown	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address JHH Date signed 6-19

C 18280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

C 18280 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gold Spring Lane
(c) Hospital or institution: Gold Spring Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3443 Sheatsley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. Duvall.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1867

8. AGE: Years 76 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Thomas B Duvall
13. Birthplace Md

MOTHER
14. Maiden Name Laura Sherwood
15. Birthplace Md

16 (a) Informant Mrs Mary Heagle.
(b) Address 3443 Sheatsley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 1944 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden.

18 (a) Funeral director Shanahan & Donovan.
(b) Address 761 S Eutaw St.

19 JUN 20 1944 (Date rec'd by Registrar) (Signature of Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944, to June 17 1944, and that I last saw h[illegible] alive on June 16 1944

Immediate cause of death: cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Fullerton
Address 7324 Reisterstown Rd Date signed 6/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47d

C 18281 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1528 W. Lanvale st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1528 W. Lanvale st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Graham.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Goldie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-10-1896

8. AGE: Years 48 | Months — | Days 6. | If less than one day hr. min.

9. Birthplace Darlington S. C. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Horace Graham

13. Birthplace S. C.

MOTHER 14. Maiden Name Rose ?

15. Birthplace S. C.

16 (a) Informant Goldie Graham

(b) Address 1528 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location A. C. County Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

19 (a) [illegible] (b) Registrar Huntington Williams, M.D.

JUN 20 1944

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16- 1944 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 26, 1943 to June 14, 1944, and that I last saw him alive on June 14, 1944.

Immediate cause of death Carcinoma of left lung — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-12-1944

Major findings of operation: Inoperable Carcinoma of left upper lobe

Findings of autopsy: No autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. R. Campbell, M. D.

Address 718 Dolphin St. Date signed 6-19-44

G 18282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 18282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Steven Shockney

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-05-4534

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estelle V. Shockney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1883

8. AGE: Years 60 | Months 8 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Vulcanizer

11. Industry or business: Frank W. Jacobs Tire Co.

FATHER
12. Name: Lorenzo D. Shockney
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Mary Jane Heaps
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Mrs. Margaret Frazier
(b) Address: 1613 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

JUN 20 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 44 at 7:50 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral hemorrhage

Due to: Arteriosclerosis

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenmaker M.D.
Medical Examiner.
Date signed 6-17-44

G 18283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G 18283

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Roland Park Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Upland Rd Roland Park Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH CORTER HOSKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Francis G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1887

8. AGE: Years	Months	Days	If less than one day
56	7	20	hr. min.

9. Birthplace Williamsport, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward H. Corter
13. Birthplace Williamsport, Pa.

MOTHER
14. Maiden Name Lucy Boyd
15. Birthplace Montoursville, Pa.

16 (a) Informant Mr. Francis G. Hoskins
(b) Address Roland Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

JUN 20 1944 (b) Huntingdon Williamsport, Pa.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH June 17, 1944 at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944 to June 17 1944 and that I last saw her alive on 6/17/44-19

Immediate cause of death Carcinoma of right breast, metathesis in right lung. — Duration about 6 mo.

Due to Inoperable carcinoma of breast.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) ~~Accident, suicide, or homicide~~
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen S Hublett M. D.
Address 2220 Harrison Blvd. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

18284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G 18284 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3523 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WIRT ADAMS DUVALL

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Roxana Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1863

8. AGE: Years 80 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Grafton Duvall
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Mary Rebecca Sullivan
15. Birthplace Annapolis, Md.

16 (a) Informant Mr. Wirt Duvall
(b) Address 307 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) JUN 20 1944 (Registrar) (b) Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941, to 6-17-1944, and that I last saw him alive on 6-17 1944.

Immediate cause of death: Chronic Nephritis - Suppression of Urine -
Duration: 3 yrs 5 mos.
Due to: Arteriosclerosis -
Due to: Coronary Occlusion 6-1-42 -
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Warner M. D.
Address 260 W. Lanvale Street Date signed 6-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 1456417 (314905)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 18285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha M Eoppler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-78

8. AGE: Years	Months	Days	If less than one day
65	5	22	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Eoppler
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Boch.
15. Birthplace Germany

16 (a) Informant Rec'nda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 20 1944 (Date rec'd by registrar) Wm. J. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June-17 1944, at 5.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944, to June-17 1944, and that I last saw h[illegible] alive on June-17 1944.

Immediate cause of death: UREMIA — Duration: 6 days

Due to: Chronic nephrosclerosis & chronic glomerulonephritis — 5 yrs

Due to: Hypertensive CV disease Generalized arteriosclerosis — 20 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Boston M.D.
Address Johns Hopkins Date signed 6/17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Write correct age is especially important.

8286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G 18286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Bentalou St. (If rural give location)
Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Olga Kanne (Olga Emma Kanne)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife August C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-80

8. AGE: Years 63 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ernest Tieperman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Marie Crawford
(b) Address 1020 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 20 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 XX at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 19 XX to 6/19 19 XX and that I last saw h[illegible] alive on 6/19 19 XX

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Severe Essential Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Rabstejnek M. D.
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

516

Registered No. G 18287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB MAYER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louisa Axt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 23, 1874

8. AGE: Years 69 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Retired Clothing Mfgtr.
11. Industry or business:

FATHER
12. Name: Max Mayer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Amelia Solomon
15. Birthplace: Germany

16 (a) Informant: Mrs. Louisa Axt
(b) Address: 2212 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory: Har Sinai
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19. JUN 20 1944 (Date received by Registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 17, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-3-1943 to June-17-1944 and that I last saw him alive on June-17-1944.

Immediate cause of death	Duration
Carcinoma of Prostate	
Due to with Metastases of lower & Liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Herman Bendel M. D.
Address 2404 Eutaw Pl. Date signed 6/19/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18288

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 33rd & Cabot Ave

(b) Street address ~~34th & Charles Sts.~~

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside Baltimore, give county and state)

(d) Street No. 34th & Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ESTELLE ALMS HOLLYDAY

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Legally Separated

6 (b) Name of husband or wife: Worthington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1881

8. AGE: Years 63 | Months 4 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Cincinnati, Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William H. Alms

13. Birthplace Ohio

MOTHER

14. Maiden Name Ann E. Bogen

15. Birthplace Ohio

16 (a) Informant Mrs. Betty Young

(b) Address Cambridge Arms Apt. (7-J)

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)

(c) Cemetery or crematory Spring Grove Cem., Location Cincinnati, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received by Local Registrar JUN 20 1944 (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2d 1943 to June 19 1944, and that I last saw h 22 alive on June 18 1944.

Immediate cause of death	Duration
Carcinomatous cachexia	6 mos
Due to Carcinoma of uterus (? body of) (?) Symptoms	7 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis P. Hamburger M. D.

Address 1207 Eutaw Pl. Date signed VI-19-44

18289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

G 18289 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 Sargeant St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Sargeant (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Muehlsien

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jack Muehlsien

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Apr 16 1894

8. AGE: Years 50 | Months 2 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, County, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Christian Hilts

FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden Name Dont Know

MOTHER 15. Birthplace Baltimore

16 (a) Informant Charles R Fuchs

(b) Address 1300 E Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Ulrich Funeral House

(b) Address 200 N Eutaw St

JUN 20 1944 (Date received by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 9 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to June 17 1944 and that I last saw her alive on June 17 1944

	Duration
Immediate cause of death: Apoplexy	1 day
Due to: Hypertension	6 mos
Due to: Chronic Nephritis	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T Nauheim M.D.

Address 1 S Fulton Ave Date signed 6/19/44

VS 150

G 18290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 18290

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Cold S primg Nursing Home

(c) Hospital or institution: 2101 W. Cold Spring Lane

(d) Length of stay in hospital or inst. (yrs., mos., or days): 2

(e) Length of stay in Baltimore (yrs., mos., or days): 15

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Baltimore

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 7203 Eastern Ave. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME: Fredrick L. Deets Deets.

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Alice V. Deets

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19, 1861

8. AGE: Years: 83 Months: 10 Days: 12 If less than one day: 9 hr. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Fire Department

11. Industry or business:

FATHER

12. Name: Don't know

13. Birthplace:

MOTHER

14. Maiden Name: Don't know

15. Birthplace:

16 (a) Informant: Mrs. Ida Reuschling

(b) Address: 3111 Rosekemp Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June 20-44 (month) (day) (year)

(c) Cemetery or crematory: Mt. Olivet

Location: Baltimore Md.

18 (a) Funeral director: Ullrich Funeral Hom e

(b) Address: 2008 Orleans St.

19 JUN 20 1944 (Date received by Local Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1944, at 2 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to June 18 1944, and that I last saw him alive on June 16 1944

Immediate cause of death	Duration
cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: M. N. Patterson M. D.

Address: 2324 Reisterstown Rd. Date signed: 6/19/44

18291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C 18291

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lanvale
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore (City)
(c) City or town Rural - Sparrows Po
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 Wyeth Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Martha Snidow

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto; Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name William Snidow
13. Birthplace Va

MOTHER
14. Maiden Name Mildred Clark
15. Birthplace Va.

16 (a) Informant Mrs. Mildred Snidow
(b) Address 2421 Wyeth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory St Paul's
Location Cardiff & Bonsal Rds Balto Co

18 (a) Funeral director Stephen J Trzebowski Inc
(b) Address 1005 D Kenwood Ave.

19 Date received by Local Registrar JUN 20 1944 Thomas J. Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17, 1944 to June 19 1944 and that I last saw her alive on June 19, 1944

Immediate cause of death Acidosis
Dehydration

Due to Prematurity (26 wks)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Tunney M. D.
Address Mercy Hosp Date signed 6/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G 18292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4800 Haddon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4802 Haddon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minerva Ann Gore

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louis Gore
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 1 1873
8. AGE: Years 70 | Months 8 | Days 16 | If less than one day hr. min.
9. Birthplace Garner N C (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nancy Smith
13. Birthplace Garner N C

MOTHER
14. Maiden Name Salina Broughton
15. Birthplace Garner N C

16 (a) Informant Louis Gore
(b) Address 4800 Haddon Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Md
Location Woodlawn Md
18 (a) Funeral director Wilson Cookerly
(b) Address 217 E Fort St

JUN 20 1944
(Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 10 A M
21. I certify that death occurred on the date above stated; that I attended deceased from June 19 43 to June 17 19 44, and that I last saw him alive on June 17 19 44.

Immediate cause of death: Heart Failure (Duration: Hours)
Due to: Arteriosclerosis Carded Vascular
Due to: Disease. (Duration: 2 years)
Other Conditions: Pregnancy 7 Mo (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos J Abbott M. D.
Address 4503 Liberty Heights Ave Date signed 6-19-44

18293 PAUL EWell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94W

G 18293 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (~~yrs., mos.,~~ or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Glenmore Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Ewell

3 (b) If veteran, name war: World War

3 (c) Social Security Account No. 322-05-2738

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Cecilia Ewell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11th 1893

8. AGE: Years 51 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Friez Co.

FATHER — 12. Name Webster Ewell

13. Birthplace Md

MOTHER — 14. Maiden Name Mary G. Kidd

15. Birthplace Md.

16 (a) Informant Cecilia Ewell

(b) Address 4002 Glenmore Av

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/22/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ U. S. National

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 JUN 20 1944 (Date rec'd by registrar) Hamilton for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1944 to 6/19 1944 and that I last saw ~~he/she~~ alive on 6/19 1944

Immediate cause of death	Duration
(a) Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Williams

Address 1400 W. Cathedral Date signed 6/19/44

G 18294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 164f

Registered No. G 18294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Lumberton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William P. Hill

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 19 1944 (Indorsed by registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8-44, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-7-44 at 9.47 P.M.
(b) Where did injury occur? E. J Hanover, Howard Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped out a window, R.R. Coach.

23. Signature Howard J. Malbein M.D.
Medical Examiner.
Date signed 6-9-44

1022

G 18295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 Registered No. G 18295

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Hanover (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barney A. Dennis.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 1897

8. AGE: Years 47 | Months 3 | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Harris Dennis
13. Birthplace North Carolina

MOTHER
14. Maiden Name Rebecca Lowry
15. Birthplace North Carolina

16 (a) Informant Barney A. Dennis
(b) Address 429 Hanover St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19YY, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 19YY, to 6-13 19YY, and that I last saw h. alive on 6/13 19YY.

Immediate cause of death	Duration
Arteriolar nephro-sclerosis	
Due to Hypertensive C-V. disease.	
Due to Cer'l. arterio sclerosis.	
Other Conditions Secondary anemia.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore L. Brazeau
Address So Balto. Gen Hosp Date signed 6/20/44

VS 189

1021

Medicolegal Case
DOA Sect. Pm 18296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

C 18296
Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Mc Elderry st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fanny White (Fannie White)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Charlie White
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-14-90
8. AGE: Years 54 Months 1 Days 5 If less than one day hr. min.
9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Bartlett
13. Birthplace N. C.

MOTHER
14. Maiden Name Cora Lee
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory Location Elizabeth City N. C.

18 (a) Funeral director Robert L. Gourley
(b) Address 804 N. Carlisle St.

19 (a) (Date rec'd by registrar) (b) Williams M.D.

JUN 20 1944 for R. Robert Leff Graham, by Howard J. Malecio, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 3:50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death — Duration

Myocardial Insufficiency
Due to Cerebral Hemorrhage
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cornecin, M.D.
Address 1414 Date signed 6-20

G 18297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 18297

MARGIN RESERVED FOR BINDING

Every item of information should be carefully answered. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Rupp

3 (b) If veteran, name war -----

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Mary Rupp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1871

8. AGE: Years	Months	Days	If less than one day
72	7	4	hr. min.

9. Birthplace Md Balto. Md.
(Town, county, and state)

10. Usual Occupation ? none

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director [redacted] Henry Sons
(b) Address 2024 Orleans St.

JUN 20 1944 Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944 at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to June 18 1944, and that I last saw him alive on June 16 1944.

Immediate cause of death	Duration
Fecal Extravasation —	5 days
Due to Undetermined cause	
Due to	
Other Conditions Carcinoma of Colon, Cardio Arterio Sclerosis	?

(Include pregnancy within 3 months of death)

Date of operation June 16 1944

Major findings of operation: Extraperitoneal abscess of colon

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Rupert M. D.
Address Balto. City Hosp. Date signed June 19 1944

G 18298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 18298 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves.
(c) Hospital or institution:
St Agnes 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore Catonsville
(a) State Md (b) County
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Beaumont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Eberhardt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie Eberhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/1879

8. AGE: Years 64 | Months 9 | Days 4 | If less than one day 14 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business "

FATHER 12. Name Henry Eberhardt
13. Birthplace Germany

MOTHER 14. Maiden Name Wagner
15. Birthplace Germany

16 (a) Informant Minnie Eberhardt
(b) Address Beaumont & Catonsville Aves

17 (a) Burial (b) Date thereof 6/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director F. D. Kaffenberger Inc
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by registrar) JUN 20 1944 (b) Huntington & Williams Mtrs

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 1944 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19XX to 6/19 1944 and that I last saw h[im] alive on 6/19 1944

Immediate cause of death Cardiac Insuff.
Due to
Due to
Other Conditions Diabetes Mellitus
Prostatic hypertrophy.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Prostatic Hypertrophy
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify other place)
(e) Means of injury

23. Signature H. L. Kaffenberger M. D.
Address St. Agnes Hosp Date signed 6/19/44

~~18299~~ G 18299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4308 Shamrock Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Shamrock Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John K. Meinhardt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Catherine Meinhardt
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 26 1860

8. AGE: Years	Months	Days	If less than one day
84	2	22	hr. min.

9. Birthplace Baltimore, Md
(Town, County, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name John Meinhardt
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs E. J. Dietrich
(b) Address 4301 Shamrock Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.
18 (a) Funeral director F. B. Hatfield & Son
(b) Address 300 Eutaw Place
19 (a) (Date received by Local Registrar) JUN 20 1944 (b) Signature of Local Registrar Hamilton A. Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/1944, at 10 M
21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944, to June 17 1944, and that I last saw him alive on June 17 1944

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Myocarditis	
Due to Arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Walter A. Pederson M. D.
3001 Shamrock Ave
Date signed June 19-44

G 18300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G 18300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Physicians office
(b) Street address 4603 Park Heights ave
(c) Hospital or institution:

(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 5 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Somerset Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Ford

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1916

8. AGE: Years	Months	Days	If less than one day
28 26	-	24	hr. min.

9. Birthplace Elizabeth Pa.
(Town, county, and state)
10. Usual Occupation Glen L. Martin
11. Industry or business Employee

FATHER
12. Name Kinlaw Ford
13. Birthplace S. C.

MOTHER
14. Maiden Name Golden Thompson
15. Birthplace S. C.

16 (a) Informant Ida Beard
(b) Address 935 Somerset St

17 (a) Removal (b) Date thereof June 22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Egg Harbor N. Jersey

18 (a) Funeral director Mrs. L. A. Elliott & Dgt.
(b) Address 1129 N. Carrollton St.

JUN 20 1944
(Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 19KK, at 11-AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema
Acute Congestive Cardiac Failure

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellers M.D.
Medical Examiner.
Date signed 6-19-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1484

Registered No. C 18301

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 E. Barney St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 E. Barney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: NETTIE CANNOX

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: Joseph Cannox
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 2/16/1864
8. AGE: Years 80 | Months 4 | Days 1 | If less than one day hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Family
(b) Address: 503 E. Barney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Ritchie Highway

18 (a) Funeral director: James L. McAnulty
(b) Address: 130 E. Fort Ave.

Date received JUN 20 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1944 to June 17 1944. and that I last saw h[illegible] alive on June 17 1944.

	Duration
Immediate cause of death: Cystitis	28 ds.
Due to: Carcinoma of Uterus	Indef
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature R. L. Campbell M.D.
Address 164 Hanover St Date signed 6/20/44

18302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 18302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland — Mercy Hospital

(b) Street address [redacted]

(c) Hospital or institution: Calvert & Saratoga Sts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 7½ mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 246 S. Exeter St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Ronald A. Benton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1943

8. AGE: Years	Months	Days	If less than one day
0	7	15	hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Ronald E. Benton
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Sartori
15. Birthplace Baltimore

16 (a) Informant Mrs. R. E. Benton
(b) Address 246 S. Exeter St.

17 (a) BURIAL (b) Date thereof 6 21 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ST. PETERS
Location BALTO.

18 (a) Funeral director George A. Forbes
Address Lloyd & Fayette

JUN 20 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 12:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944, to June 18 1944, and that I last saw him alive on June 18 1944.

Immediate cause of death	Duration
Terminal Pneumonia	
Respiratory failure	
Due to [redacted]	
Due to Encephalitis	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Encephalitis Pneumonia Left upper lobe

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C. Ellsworth Cook Jr. M.D.

Address Mercy Hospital Date signed June 19 -44

VS 150

G 18303

454242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18303 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-39

8. AGE: Years	Months	Days	If less than one day
4	7	19	hr. min.

9. Birthplace N. Ca. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name John Jordan
13. Birthplace N. Ca.

MOTHER
14. Maiden Name Effie Harris
15. Birthplace N. Ca.

16 (a) Informant Reeds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/44 (month) (day) (year)
(c) Cemetery or crematory
Location Rockyboro, N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradley ave Huntington Park, Cal.

19 (a) (Filed by registrar) Registrar

JUN 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944 to June 14 1944 and that I last saw h[illegible] alive on June 14 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No P.M.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: M
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. K. Cartwright M.D.

Address Johns Hopkins Date signed 6/21/44

C 18304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. C 18304

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Baltimore~~ Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Lauraden ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Wagner (AMELIA C. WAGNER)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mr. Frank Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1884
8. AGE: Years 59 | Months 11 | Days 19 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Henry Hucker
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Reichard
15. Birthplace Germany

16 (a) Informant Florence Miller
(b) Address 3001 Lauraden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Lasky Funeral Home
(b) Address 7401 Belair Road

19 JUN 20 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 1944, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1944, to 6/19/1944 and that I last saw h[illegible] alive on 6/19 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Carcinoma Head &	
pneumonia & pneumitis	
Due to abscess.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/11/44
Major findings of operation: Ca of head & pneumonia
of autopsy: Ca head & pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Cliff Rafell Jr. M.D.
Address University Hosp Date signed 6/19/44

G 18305 — Ger. Meth. — 1918 Eutaw Place — BALTIMORE CITY HEALTH DEPARTMENT — G 18305

CERTIFICATE OF DEATH V H 9C

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 Edgevale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Edgevale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabel M. von Schrader

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Walter S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1873

8. AGE: Years	Months	Days	If less than one day
70	8	14 24	hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER — 12. Name Augustus F. Dames
13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Elizabeth Bofliff
15. Birthplace England

16 (a) Informant Mrs Ruth V.S. Stinson
(b) Address 202 Edgevale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 20 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Wm Gorsuch
(b) Address 1217 St Paul St.
19 (a) JUN 20 1944 Thurlington Williams, M.D. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944 at 3 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1939 to 6-17 1944 and that I last saw h[illegible] alive on 6-17 1944

Immediate cause of death Vaginal Carcinoma — Duration

Due to Liver — Duration

Due to Coma — Duration

Other Conditions None. — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodosia Krull M.D.
Address 1418 Eutaw Pl Date signed 6-19-44
Balto Md

G 18306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/93N G 18306 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2339 Frederick Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2339 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie S. Burruss

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Burruss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st, 1864

8. AGE: Years	Months	Days	If less than one day
79	10	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Isaac Hamburger

FATHER
12. Name Unknown Campbell
13. Birthplace (Unknown)

MOTHER
14. Maiden Name Nancy Scott
15. Birthplace (Unknown)

16 (a) Informant Miss Jeannette, Hohman
(b) Address 134 N. Bradford St.

17 (a) Burial (b) Date thereof 6/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

JUN 20 1944
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th. 1944, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1943, to June 19 1944, and that I last saw h or alive on June 17 1944

Immediate cause of death	Duration
Coronary Thrombosis	
Due to arteriosclerotic	
Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kemp M. D.
Address 3030 Edmondson Ave. Date signed 6/20/44

G 18307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51b

G 18307
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct and specially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County
(c) City or town Parkmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8610 Old Hayes Rd 14
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Klare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Margaret M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1866

8. AGE: Years 77 | Months 7 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Andrew J. Klare
13. Birthplace France

MOTHER
14. Maiden Name Susan Silvus
15. Birthplace Pa.

16 (a) Informant Mabel Hyde
(b) Address 8610 Old Hayes Rd, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 44 (month) (day) (year)

(c) Cemetery or crematory Bradford Ave
Location Woodlawn Rd

18 (a) Funeral director Leonard Hook
(b) Address 5205 Harford Rd.

JUN 20 1944

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1944, to 6-19 1944
and that I last saw h. alive on 6-12 1944.

Immediate cause of death: Pulmonary Edema — Duration: ____
Due to Arteriosclerotic C.V.D. — Duration: ____
Due to ____ — Duration: ____
Other Conditions Uremia, acute Uremia, Retentio, Carcinoma — Duration: ____
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ____
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Cregram
Address Univ. Hospital Date signed 6/19/44 M. D.

G 18308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 18308 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hosp 2356 1408
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Martha Baby Girl Lemon

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Baby

6 (b) Name of husband or wife Baby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 44

8. AGE: Years	Months	Days	If less than one day
	2	14	hr. min.

9. Birthplace Baltimore City Md (Town, county, and state)
10. Usual Occupation Baby.
11. Industry or business —

FATHER
12. Name Thomas Lemon
13. Birthplace - S. C

MOTHER
14. Maiden Name Janie Hudgins
15. Birthplace - S. C

16 (a) Informant Janie Lemon
(b) Address 142 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (Signature of registrar) Huntington Williams, M.D.
JUN 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 3.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944 to June 19 1944 and that I last saw h.e.r alive on June 18 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions Syphilis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Leibman, Jr. M.D.
Address University Hosp. Date signed 6/21/44

C 18309 PIERRO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 18309 Registered No. 1276

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Av. & Dukeland St.
(c) Hospital or institution: West Balt. Gen'l. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
Street No. 6840 FAIT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTOINETTE PIERRO

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Joseph Pierro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21 1911

8. AGE: Years 33 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Flushing Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Donato Muscello
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Facciutti
15. Birthplace Italy

16 (a) Informant Joseph Pierro (Husband)
(b) Address 6840 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German hill Rd. Balti. M.D.

18 (a) Funeral director Frank Della Rocca
Address 52 N. Morley St.

19 (a) JUN 20 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18/44 19 , at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1944 to 6/18 1944, and that I last saw her alive on 6/18 1944.

Immediate cause of death	Duration
UREMIA	
PULMONARY INFARCTION	
Due to RENAL FAILURE	
Due to CHRONIC-OBSTRUCTIVE-JAUNDICE	
Other Conditions Prolonged P.O. Surgical Shock	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Duncan H. Cheshire M.D.
Address WBGH Date signed 6/19/44

T.G.P. 87490 G 18310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18310 Registered No. 870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 So. Potomac Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mario Mancini

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-20-8260

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7 1926

8. AGE: Years 18 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Mancini
13. Birthplace Italy

MOTHER
14. Maiden Name Agostina Moscetti
15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) Filed by registrar JUN 20 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944 to 6/18 1944 and that I last saw him alive on 6/18 1944

Immediate cause of death: Multiple sclerosis — Duration: ?

Due to

Due to

Other Conditions: Cystitis, small post. infarct, left. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Simpson M. D.
Address BCH Date signed 6/19

18311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

E 18311 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 209 S. Grundy

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 209 S. Grundy (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Santa Settimio

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widoved

6 (b) Name of husband or wife late Joseph Settimio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 1868

8. AGE: Years	Months	Days	If less than one day
75	9	25	hr. min.

9. Birthplace Mosciano S. Angelo Italy (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name Francesco Martini

13. Birthplace Italy

MOTHER

14. Maiden Name Giuseppina ?

15. Birthplace Italy

16 (a) Informant Mary Mattiucci (Daughter)

(b) Address 209 S. Grundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) (By) Registrar

(Date rec'd by registrar) JUN 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1942 to June 18 1944, and that I last saw her alive on June 17 1944.

Immediate cause of death	Duration
Chr. Myocarditis	?
Due to Chr. arterio-Sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature N. J. Dondor M. D.

Address 3218 Eastern Ave Date signed 6-20-44

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

G 18312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G 18312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Bognanni

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 216-10-4384

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Marietta Bognanni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1890

8. AGE: Years 53 | Months 9 | Days 5 | If less than one day: hr. min.

9. Birthplace Calascibetta Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Tailor Shop

MOTHER / FATHER
12. Name Late Giovanni Bognanni
13. Birthplace Calascibetta Italy
14. Maiden Name Vincenza Petralia
15. Birthplace Calascibetta Italy

16 (a) Informant Marietta Bognanni (Wife)
(b) Address 2326 Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

JUN 20 1944 (Date rec'd by registrar) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 | 19 | 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 | 13 | 1944, to 6 | 19 | 1944, and that I last saw h[illegible] alive on 6 | 19 | 1944

Immediate cause of death: Peritonitis — Duration:

Due to: Post op - cholecystectomy.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 6/15/44

Major findings of operation: Empyema of Gall Bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Steinberg

Address Sinai Hospital Date signed 6/19/44

STEINBERG

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G 18313 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 N. Morley st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Herbert G. Kraft~~ Herbert G. Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jul 22 1934

8. AGE: Years 9 | Months 10 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name John P. Kraft
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Crockett
15. Birthplace Va.

16 (a) Informant John P. Kraft (Father)
(b) Address 44 N. Morley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Hoce
(b) Address 52 N. Morley St.

19 (a) JUN 20 1944 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19- 1944, at 1-10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-19-44 at 20/6 11.35 A. M. Date of Ex.
(b) Where did injury occur? Gwynns Falls Quarry
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell into falls.

23. Signature Thomas J. Curran M.D. Medical Examiner.
Date signed 6-19-44

Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G 18314

CERTIFICATE OF DEATH

Registered No. 8304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Parkmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Parkmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis H Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Becker
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Apr 6 - 1881

8. AGE: Years 62 | Months 8 | Days – | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Standard Oil

FATHER — 12. Name Philip Becker
13. Birthplace Balto

MOTHER — 14. Maiden Name Dont Know
15. Birthplace Baltimore

16 (a) Informant Elizabeth Becker
(b) Address 4203 Parkmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21/44 (month) (day) (year)
(c) Cemetery or crematory Balto Cemetery
Location Balto Md

18 (a) Funeral director Ulman Funeral Home
Address 2008 Orleans St

19 (a) JUN 20 1944 (b) Registrar
(Date received)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 6 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1944 to 6-18 1944 and that I last saw h alive on 6-18 1944

Immediate cause of death — Cerebral Hemorrhage — Duration 6-18-44
Due to Arteriosclerosis
Due to a Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Lloyd Dyson Jr M.D.
Address 5407 Belair Rd Date signed 6-19-44

G 18315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G 18315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas H. Poole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1865

8. AGE: Years	Months	Days	If less than one day
79	3	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Harford County

MOTHER
14. Maiden Name Isabelle Wright
15. Birthplace Harford County

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location Harford Co. near Bel Air Md

18 (a) Funeral director Deaver & Foster
(b) Address Bel Air Md

19 (a) (Signature of local registrar) (b)

JUN 20 1944

VS 150

MEDICAL CERTIFICATION 8.30a

20. DATE OF DEATH June 20 1944, at M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 20 1944, and that I last saw him alive on June 19 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to: Fall down 3 flights	
Due to:	
Other Conditions: Chronic myocarditis (Include pregnancy within 3 months of death)	3 yr

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 20-1944 at 6-30 A M
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Sisters of Poor (Specify type of place) While at work? No
(e) Means of injury Fell down flights

23. Signature E. Gill Hall M. D.

Address 1631 E North Ave Date signed 6/20/44

Hunting for Williamsburg Md
Approved by Howard J Meneven M.D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. C 18316

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Franklin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/14/44

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name William D. Franklin
13. Birthplace Union, So.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant William Franklin
(b) Address 1616 Division

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 16 1944, and that I last saw h. alive on June 16 1944.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Bonfield
Address President Hospital Date signed 6/17/44

1025

G 18317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 2

G 18317

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 251 Baltimore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brickhead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-16-44

8. AGE: Years | Months | Days 43 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Brickhead
13. Birthplace VA

MOTHER
14. Maiden Name Shislet
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 21-44 (month) (day) (year)
(c) Cemetery or crematory Markwood
Location Charlottesville N. C.

18 (a) Funeral director Lilly & Delaplaine
(b) Address 1904 W. Baltimore Ave

JUN 30 1944 (Date) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 9.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944, to June 19 1944, and that I last saw her alive on June 19 1944.

Immediate cause of death: Cardiac failure — Duration

Due to: Cong. Stenosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Kaye M.D.

Address Date signed

G 18318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83w

G 18318

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 S.BOND ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S.BOND ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOSEPH KOTOWSKI

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ANIELA KOTOWSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR.19 1875

8. AGE: Years 69 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace POLAND
(Town, county, and state)

10. Usual Occupation RETIRED LABORER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant STANLEY L.KOTOWSKI(SON)
(b) Address 2209 DUKER COURT

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 22/44 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

19 JUN 20 1944 (b) Registrar

Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 19 1944, at 3 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to June 19 1944 and that I last saw h.m. alive on June 17 1944

Immediate cause of death: Cerebral Hemorrhage
Due to Telencephalitis
Due to Arterio Sclerosis
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Andrew Kunkowski M. D.
Address 7379 Eastern Ave. Date signed 6

G 18319 G 18319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 758 Bradley St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 758 Bradley St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rena Mapp.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-18-1879

8. AGE: Years 64 65 | Months 4 10 | Days — | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business .....

FATHER 12. Name Unknown
13. Birthplace .....

MOTHER 14. Maiden Name Unknown
15. Birthplace .....

16 (a) Informant Edward Watson Jr.
(b) Address 724 Fairmont St N.E. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location Baltimore Md

18 (a) Funeral director William A. Hudson
(b) Address 916 Penna ave

19 (a) JUN 20 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 18 1944.
and that I last saw h[illegible] alive on 6/18 1944.

Immediate cause of death: Arteriosclerosis
Cardiac Decompensation
Due to Bird chase

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....

of autopsy: .....

Duration: Study

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify public place)
(e) Means of injury .....

23. Signature [signature] M. D.
Address 74 E Eager Date signed 6/19/44

G 18320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 18320 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4002 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Norfolk Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Durr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Minnie J. Durr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1867

8. AGE: Years 77 | Months 3 | Days — | If less than one day ____ hr. ____ min.

9. Birthplace York, Pennsylvania
(Town, county, and state)

10. Usual Occupation Pres.-General Machinery and Supply Co.

11. Industry or business

FATHER
12. Name John T. Durr
13. Birthplace Germany

MOTHER
14. Maiden Name Rosanna Caroline —
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof June 22-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Pennsylvania

18 (a) Funeral director Bugge Funeral Home
(b) Address 3631 Falls Rd

19 (a) JUN 20 1944 (b) Hunter for Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19/44 at 11:29 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 6/20/44.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 18321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 7N D 18321 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution St. Agnes Hosp. Y
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4708 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Uhlhorn

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Juanita M. Uhlhorn

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 17-1880

8. AGE: Years 63 | Months 7 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Evansville Indiana
(Town, county, and state)

10. Usual Occupation Machinery Business

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Juanita M. Uhlhorn
(b) Address 4708 Norwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Ellsworth Armgeost
(b) Address 3911 Liberty Heights Ave

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

JUN 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1944 at 8:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 1944 to 6-18 1944; that I last saw him alive on 6-18 1944

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-19-44

Major findings of operation: Bx. gr. Prostate Hyperthrophy. Hemorrhoids

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. M. Smith M. D.

Address St. Agnes Hosp. Date signed 6/18/44

G 18322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

594

G 18322 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 E. 32nd St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Virginia Stickles (nee Furr)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Henry B. Stickles
6 (c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Feb. 1, 1866
8. AGE: Years 78 | Months 4 | Days 18 | If less than one day ____ hr. ____ min.
9. Birthplace Clarke County, Virginia (Town, county, and state)
10. Usual Occupation Homemaker
11. Industry or business —

FATHER
12. Name William Furr
13. Birthplace Clarke Co., Virginia

MOTHER
14. Maiden Name Margaret Beatty
15. Birthplace Clarke Co. Virginia

16 (a) Informant H. B. Stickles
(b) Address 1720 E. 32nd St. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson

18 (a) Funeral director Landon M. Brooks
(b) Address Govans, Md.

19 (a) (Date received by Registrar) JUN 20 1944 (b) Filed

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1944 to June 19 1944, and that I last saw her alive on June 18 1944.

	Duration
Immediate cause of death: Myocardial Insufficiency	3 days
Due to: Arthritis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. L. Simpson M. D.
Address 4857 Harford Rd Date signed 6/19/44

G 18323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 a

G 18323 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations except where space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406-1/2 Brohawn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Barker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Wilbur D. Barker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1872

8. AGE: Years 72 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name James V. Pilcher
13. Birthplace Harpers Ferry, W. Va.

MOTHER: 14. Maiden Name Mary Ellen Warford
15. Birthplace West Virginia

16 (a) Informant Mr. James F. Barker
(b) Address 2406-1/2 Brohawn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamoreux
(b) Address 4510 Liberty Heights Ave.

JUN 20 1944 (Filed by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 4.50P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944, to 18 1944, and that I last saw her alive on June 18 1944.

Immediate cause of death: Chronic Nephritis — Duration 1 year
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schaffer M. D.
Address 2301 Annapolis Blvd. Date signed

G 18324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G 18324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4129 Fifth St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4129 Fifth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara J. Platzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Late Charles J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28th 1868

8. AGE: Years	Months	Days	If less than one day
75	9	22	hr. min.

9. Birthplace Washington, D.C. (town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name P Lindner
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace Washington, D.C.

16 (a) Informant Mrs Charles B. Platzer
(b) Address R.F.D. #2 Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave.

18 (a) Funeral director Earl T. Hess
(b) Address 711 Light St.

19 (a) JUN 21 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th 1944, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943, to June 19 1944, and that I last saw h[illegible] alive on June 19 1944.

Immediate cause of death	Duration
Apoplexy	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W. Lewis, M.D.
Address 302 Bellevue Date signed 6/20/44

VS 150

Dr. Palas

G 18325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131 h

G 18325 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1948 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1948 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Hoffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife John Hoffman (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 - 1888

8. AGE: Years	Months	Days	If less than one day
57	2	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Cunningham
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigid Flannery
15. Birthplace Ireland

16 (a) Informant Mrs. Helen M. Euhlhorn
(b) Address 1948 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director Thomas J. Kenny
(b) Address Hollins & Gilmor Sts.

19 JUN 21 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1944 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1944 to 6/18 1944 and that I last saw her alive on 6/16 1944

Immediate cause of death	Duration
Acute cardiac dilation	2 hrs.
Due to Chronic myocarditis	1 yr.
Due to	
Other Conditions Chronic nephritis (Include pregnancy within 3 months of death)	2 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town), (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Palas.
Address 4 N. Fulton Date signed 6/24/44

18326 BALTIMORE CITY HEALTH DEPARTMENT 14 Registered No. C 18326

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8109 Cornwall Rd. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Louis Alexander, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1944

8. AGE: Years	Months	Days	If less than one day: hr.	min.
2	3	2		442

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Louis Alexander, Sr.
13. Birthplace ~~Balto~~ Ohio

MOTHER
14. Maiden Name Geraldine Rossbach
15. Birthplace Baltimore

16 (a) Informant Louis Alexander, Sr.
(b) Address 8109 Cornwall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Irvington Hall Rd.

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) JUN 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 6:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to June 18 1944, and that I last saw him alive on June 18 1944

Immediate cause of death	Duration
Bulbar Paralysis	—
Due to Tuberculous Meningitis	15 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature F. Ellsworth Cook, Jr. M.D.
Address Mercy Hospital Date signed June 18 '44

18327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18327 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S.A. University Hosp. ward 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George a. Vinson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1868

8. AGE: Years	Months	Days	If less than one day
75	7	1	hr. min.

9. Birthplace Portland Maine (Town, county and state)

10. Usual Occupation Jeweler

11. Industry or business self

FATHER 12. Name Alexander Winson

13. Birthplace England

MOTHER 14. Maiden Name Lucy Bause

15. Birthplace England

16 (a) Informant Mrs. G. R. Wallbach

(b) Address 2308 Roslyn Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/22/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Western

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 5 St. Paul st.

19 (a) (Date rec'd by registrar) JUN 21 1944 (b) Registrar

Hawkins & Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 3:05 P M

21. I certify that I took charge of the remains described above, held an Inquiry-Inspection and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Charles J. Turbinski M.D. Medical Examiner.

Date signed 6/19/44

PLEASE WRITE PLAINLY, WITH ONE WORD IN EACH SPACE. Fill in all blanks correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 ✓

G 18328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1733 Patapsco St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Baynes Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-4700

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Marie M. Baynes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1891

8. AGE: Years	Months	Days	If less than one day
52	10	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Gas + Electric Co

FATHER
12. Name John Baynes
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Minnie (Unknown)
15. Birthplace "

16 (a) Informant Marie M. Baynes
(b) Address 1733 Patapsco St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/23/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glen Burnie Md.

18 (a) Funeral director William Cook Inc
Address 1217 St. Paul St
(b)

JUN 21 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1944 to June 20 1944, and that I last saw him alive on June 20 1944

Immediate cause of death Pulmonary tuberculosis with marked cavitation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Lubato M. D.
Address 1213 Light St. Date signed 6/20/44

VS 159

G 18329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117W

Registered No. G 18329

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1181 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mae Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hetta -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 66 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

MOTHER / FATHER

12. Name Paul Levin

13. Birthplace Russia

14. Maiden Name Nurdam -

15. Birthplace Russia

16 (a) Informant Mrs. Simon Nelson (Daughter)

(b) Address 1181 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-44 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel

Location Northern Ave.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto. St

19 (a) [illegible] JUN 21 1944 [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 7:02 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944, to June 20 1944, and that I last saw him alive on June 20 1944.

Immediate cause of death	Duration
Pulmonary edema	
Due to heart failure	
Due to peritonitis	
Other Conditions gastric resection	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Chronic gastric ulcer

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.

Address Sinai Hosp Date signed 6/20/44

G 18330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18330 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Renty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lena -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1867

8. AGE: Years 76 | Months 10/11 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George
13. Birthplace Baltimore

MOTHER 14. Maiden Name Caroline Ely
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Jno. A. Adrian
(b) Address 420 Greenmount Ave

19 (a) JUN 21 1944 (Date received by Registrar)

Hunting to Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 1. a. m. M

21. I certify that death occurred on the date above stated; that I attended deceased from May-22 1944, to June 19 1944, and that I last saw h[illegible] alive on June 18 1944

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E Northave Date signed June 19-44

G 18331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G 18331

20 #88495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Potomac St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Genevieve Goldstrom or Jeanette Goldstrom

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Solomon
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1889

8. AGE: Years 54 | Months -9- | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Frank Malone
13. Birthplace Maryland
14. Maiden Name Mary Ellen Kelley
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22-44 (month) (day) (year)
(c) Cemetery or Crematory Oak Lawn
Location Eastern Ave. & Pulaski Hy.

18 (a) Funeral director John A. McGarry
(b) Address 3900 E. Baltimore St.

19 (a) JUN 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1944 to 6/18 1944, and that I last saw h[illegible] alive on 6/18 1944.

Immediate cause of death Bronchopneumonia

Due to.....

Due to.....

Other Conditions HCVD & cerebral hemorrhage & hemiplegia; ASCVD
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation.....
of autopsy: No post

Duration
.....
.....
.....
.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

M.D. Signature E. L. Seigman
Address 13 E 14 Date signed 6/19

G 18232 ✓ G 18332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131N

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 16th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard T. Higgins

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-03-2086

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna Higgins 6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 23, 1889

8. AGE: Years 54 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Painter's Helper

11. Industry or business Frank C. Long Sons

MOTHER / FATHER

12. Name Wallace Higgins

13. Birthplace Maryland (Balto.)

14. Maiden Name Harriett Bradley

15. Birthplace Maryland

16 (a) Informant Mrs. Annie Higgins

(b) Address 1801 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto. Md.

19 (a) JUN 21 1944 (Date rec'd by Local Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1944, at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944 to June 20, 1944 and that I last saw h. alive on June 20, 1944

Immediate cause of death: Cardio Respiratory Failure — Duration: ?

Due to: Hypertensive Cardio Renal Disease — Duration: 3 months

Other Conditions: Uremia Heart failure (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Enlarged Heart

of autopsy: no autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R. Davis Jr. M.D.

Address Mercy Hospital Date signed 6/28/44

G 18333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18333 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1654 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1654 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN S. REUTHER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Frances
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 22, 1873
8. AGE: Years 70 | Months 8 | Days 25 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Paramount Roofing Co.

FATHER
12. Name Henry Reuther
13. Birthplace Md.

MOTHER
14. Maiden Name Susan (unknown)
15. Birthplace Md.

16 (a) Informant Mr. John H. Riedeman
(b) Address 1654 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 21 1944 (b) (Registrar)

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1944 to 6/17 1944 and that I last saw h[illegible] alive on 6/17 1944

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerotic Cardiovascular Disease — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D. Bloom, M.D.
Address 1266 E. Preston St Date signed 6/22/44

G 18334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

G 18334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony run Lane
(c) Hospital or institution: McKenna Mem. Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5211 Springlake Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ELIZABETH HESS

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jere M. Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1856

8. AGE: Years	Months	Days	If less than one day
88	0	6	hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Hezekiah B. Stevens
13. Birthplace N. H.

MOTHER
14. Maiden Name Mary E. Kimball
15. Birthplace N. J.

16 (a) Informant Mr. Lawrence J. Hess
(b) Address 5211 Springlake Way

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory
Location Evanston, Ill.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) (b) [illegible], M.D.
VS-1M JUN 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1944, at 7.22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944, to June 19 1944, and that I last saw her alive on June 19 1944.

Immediate cause of death	Duration
Thrombosis of Popliteals (gangrene)	2 wks.
Due to Arteno-Sclerosis	12 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer A. Dodd M.D.
Address 735 N. Fulton Av. Date signed 6/20/44

G 18335 ✓ G 18335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 451 Lorraine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 E. Lorraine Ave. (If rural give location) 451
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINE E. RICHARDS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert E. Richards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/1914

8. AGE: Years 30 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Sumter, S. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ralph H. Robosson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Hile
15. Birthplace Balto., Md.

16 (a) Informant Mr. Albert E. Richards
(b) Address 451 Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 21 1944 (Date received by Registrar) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1944, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to June 19 1944 and that I last saw h[er] alive on June 19 1944

Immediate cause of death: Carcinoma of Cervix — Duration: 8 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cohnman M.D.
Address 19 W Richmond Date signed 6/20/44

G 18336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 18336 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Park Apts. Balto (If rural give location)
Beech Ave. & 49th St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Lanford Carter

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Bertha K. Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3 1870

8. AGE: Years 73 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Balto.) (Town, county, and state)

10. Usual Occupation Vice-Pres.

11. Industry or business Baker Whitley Coal Co.

FATHER 12. Name Presley Ambrose Carter

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Anna Hutt

15. Birthplace Virginia

16 (a) Informant Mrs. Bertha K. Carter, wife

(b) Address Wyman Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by registrar) JUN 21 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 12 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 19 19XX, and that I last saw h.im alive on June 17 19 44

Immediate cause of death C-V failure. | Duration

Due to Diabetic Coma

Due to

Other Conditions Senile Gangrene Bronchopneumonia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill III M. D.

Address Union Memorial Hosp Date signed 6-19-44

G 18337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 454

Registered No. G 18337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Tunbridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Tunbridge Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H. TAG

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife A. Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	0	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Owens Ill Can Co.

FATHER
12. Name Jean Tag
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Schweinsberger
15. Birthplace Germany

16 (a) Informant Miss Dorothea Tag
(b) Address 611 Tunbridge Rd. 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUN 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1944, at 4.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 11 1940, to June 19 1944 and that I last saw h. alive on June 18 1944

Immediate cause of death	Duration
Carcinoma of Lungs	5 Mos
Due to Carcinoma of Tongue	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature J. H. Thomas M. D.
Address 3136 Keswick Rd Date signed 6/20/44

G 18338 ✓ G 18338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~3126~~ 110 N. Calhoun St
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Weaver Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Otto Carl Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec 28 1889

8. AGE: Years 54 0-6 | Months 5 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Salesman - H.K.&Co.

11. Industry or business

FATHER 12. Name Henry Becker
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Dietrich
15. Birthplace Md

16 (a) Informant Mrs. Madge A. Becker
(b) Address 3126 Weaver Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-44 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location

18 (a) Funeral director Frank Hayes
(b) Address 1544 Harlem Ave

19 JUN 21 1944 (Must be filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 | 20 | 19 44, at 1050 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 | 20 | 44 19 to 6 | 20 | 44 19, and that I last saw h alive on 6 | 20 | 44 19.

Immediate cause of death: Cerebral Hemmorhage — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Sturm
Address Franklin Square Hosp Date signed 6/20/44

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS 2

G 18339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 18339 ✓

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore & Charles Sts.
(c) Hospital or institution: B & O R.R.Building
(d) Length of stay in hospital or inst. (yrs., mos., or days): 16
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: J.Chapman Laupus,

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 212-07-2779

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Bertha P.Laupus,
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.): February 20.1880

8. AGE: Years	Months	Days	If less than one day
64 63	4	-	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: B & O R.R.

FATHER
12. Name: George H.Laupus,
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Sophia Weidemier
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs Bertha P.Laupus,
(b) Address: 3003 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 23,1944 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore Md.

18 (a) Funeral director: Robert S.Little,
(b) Address: 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 21 1944 Huntingdon & Williamsport, Pa

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUN 20 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to June 20 1944, and that I last saw h.. alive on June 18 1944

Immediate cause of death: Coronary Thrombosis

Due to: Hypertension and Myocarditis

Due to:

Other Conditions: Chronic Nephritis.
(Include pregnancy within 3 months of death)

Date of operation: ✓

Major findings of operation: ✓

of autopsy: ✓

Duration
6 M

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ✓
(b) Date of occurrence: ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury: ✓

23. Signature: Bernard T. Tennel M. D.
Address: 737 Arunah Ave Date signed: 6/30/44

Rgstr.—9-30—A. & Co.—250 Blks.

FONDA

G 18340

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18340

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wyman Park apts ST. Beach ave + 49th WARD) 30d

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Caldwell Fonda

(a) RESIDENCE No. Wyman Park Apt ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married (widowed, or divorced) HUSBAND of (or) WIFE of Wm Bayard Fonda

6 DATE OF BIRTH (month, day, and year) May 26 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila (State or country) Pa.

PARENTS

10 NAME OF FATHER Chas. Caldwell

11 BIRTHPLACE OF FATHER (city or town) Phila (State or country) Pa

12 MAIDEN NAME OF MOTHER Helen Lafayucade

13 BIRTHPLACE OF MOTHER (city or town) Phila Pa (State or country)

14 Informant Bayard P. Fonda
(Address) 602 Woodbine ave Towson

15 Filed ....., 19 ..... Registrar

JUN 21 19 44 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20. 1944

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1943, to June 19, 1944

that I last saw h.. alive on June 19, 1944

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

arteriis & coronary

sclerosis. —

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary sclerosis

(duration) yrs. 3 mos. 10 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Palmer H. Wilson M. D.

6/23 19 44 (Address) Pikesville. Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION [redacted] DATE OF BURIAL
Green Mount June 22 19 44

20 UNDERTAKER ADDRESS
Henry W. Jenkins Sons Co McCulloh & Orchard Sts.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 18341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18341 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Oxford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-3667

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1901

8. AGE: Years	Months	Days	If less than one day
42	8	21	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Labober
11. Industry or business

FATHER
12. Name William Hamilton
13. Birthplace Md.

MOTHER
14. Maiden Name Leah Adams
15. Birthplace Md.

16 (a) Informant Mrs. Frederick Hamilton
(b) Address Harmon's A.A. Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (month) (day) (year)
(c) Cemetery or crematory St. Rest Cem.
Location Harmon's A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) JUN 21 19 (Signature of registrar) Kathryn [illegible] Registrar, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 20, '44 19 , at 9:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 19 44 to 6/19 19 44 and that I last saw [illegible] alive on June 19 19 44

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions Chronic Nephritis Ulcer of Stomach.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan D. Gilkes M. D.
Address 601 N. Calhoun Date signed 6/20/44

GILKES

G 18312-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G 18312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 212 Stoney Run Lane

(c) Hospital or institution: McKenna Memorial Clinic

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks

(e) Length of stay in Baltimore (yrs., mos., or days) 10 wks

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County — ? —

(c) City or town Chesterfield

(If outside city or town limits, write RURAL and give town)

(d) Street No. — ? —

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** John Wilson Gould

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1872

8. AGE: Years 71 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER — 12. Name James Alf. Gould

13. Birthplace Balto.

MOTHER — 14. Maiden Name Mary Wilson

15. Birthplace Balto.

16 (a) Informant Mrs Estelle Richardson (sister)

(b) Address 3 Whitfield Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville

18 (a) Funeral director Stewart & Mowen Co.

(b) Address 108 W. Mount Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 21 1944

Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19 1944, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 6/19 1944, and that I last saw h. alive on 6/16 1944

Immediate cause of death	Duration
Starvation	
Neoplasm	
Due to Cancer of Esophagus	6 Months
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Stinchcomb Ford

Address 20 E. Preston St. Date signed 6/20/44 M.D.

G 18343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

516

G 18343

Registered No.

10 #87701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? Cheapside Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Watts

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. ?, 1873

8. AGE: Years	Months	Days	If less than one day
70	8	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cutter
11. Industry or business

FATHER
12. Name James Watts (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie O'Connora
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md
18 (a) Funeral director Flynn & Fleming
(b) Address 1424 Light St
19 (a) (D... by ... JUN 21 1944 ... Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944, at 3:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1944 to June 17 1944 and that I last saw him alive on June 16 1944.

Immediate cause of death: Uremia — Duration: 6 hours
Due to: Carcinoma of Prostate — Duration: ?
Due to: — Duration:
Other Conditions: Generalized arteriosclerosis — Duration: ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos J Bierpaul M. D.
Address Balto & Lightway Date signed June 22 1944

B 18344 G 18344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

77c

Registered No. B 18344 G 18344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 885 Tyson Ste (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Thomas Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
21 20			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jerry Baker
13. Birthplace Md.

MOTHER
14. Maiden Name Eunice Collier
15. Birthplace Ga.

16 (a) Informant Eunice Baker
(b) Address 885 Tyson Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

(a) JUN 21 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 6:45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Cn Graham M.D.
Medical Examiner.
Date signed June 19, 1944

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18345
C 18345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1932

Registered No. C 18345
C 18345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
DoA Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 E Hiring St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Emma Queens.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name George Washington
13. Birthplace Va

MOTHER 14. Maiden Name Washington
15. Birthplace Va.

16 (a) Informant Sheppard Washington
(b) Address 209 Evans Sq. N.W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

JUN 21 1944 (a) (Date rec'd by registrar) Howard Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1944, at 2:30 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 6/19/44

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 18346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 18346 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 246 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mildred Boston Butler Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: B

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1906

8. AGE: Years 37 | Months 6 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Clarence Washington
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Sadie Johnson
15. Birthplace Baltimore, Md

16 (a) Informant Sadie Johnson
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) (Signature of registrar)

JUN 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944 at 10.5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to June 17 1944 and that I last saw her alive on 6-14 1944

Immediate cause of death: Respiratory failure

Due to: Carcinoma

Due to: Anesthesia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-17-44

Major findings of operation: Biopsy Tumor of neck

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Nye Cooper M. D.
Address Univ. Hospital Date signed 6-17-44

209920
18347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 f G 18347
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Meredith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Blk | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert Meredith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-83

8. AGE: Years 60 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Frankein
13. Birthplace (Md)

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie A. Williams
(b) Address 322 N Schroeder St

19 (a) (Signature of Registrar) (b) Registrar

JUN 21 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19-1944, at 8 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15-1944 to 6-19-1944, and that I last saw h.r alive on 6-19 1944

Immediate cause of death: Carcinoma of gall-bladder with metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Abraham Goneain
Address 1 E H Date signed 6-21 (M. D.)

G 18348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18348

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution: U. S. Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 680 Josephine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEWIS JOSHUA SIDDONS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/74

8. AGE: Years	Months	Days	If less than one day
69	8	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Captain of Barge
11. Industry or business

FATHER
12. Name Lewis Daniel Siddons
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Caulk
15. Birthplace Baltimore, Md.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) JUN 21 1944 (Date rec'd by registrar) (b) Henrietta Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1944, 12:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5, 1944, to June 17 1944, and that I last saw him alive on June 17, 1944

Immediate cause of death — Duration

Carcinoma of Larynx — 6 mo

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. Crawford M. D.
Address Baltimore, Md. Date signed 6/17/44

G 18349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 18349 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia (Georgiana) Locke Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Chaton Hall

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1889

8. AGE: Years 55 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph C. Locke
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Annie Julia Wilson
15. Birthplace Md

16 (a) Informant Wortham Hall
(b) Address 902 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Joseph C. Locke, Jr.
(b) Address 1314 N. Central Ave

19 (a) (Date rec'd by Local Registrar) (b) Registrar's

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19/1944 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1943, to June 19 1944 and that I last saw h[illegible] alive on June 18 1944.

Immediate cause of death Carcinoma of the mammary gland — Duration

Due to Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Ed. Fischer M. D.
Address E. Monument Date signed 6-21-44

G 18350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 18350

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to get exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Cambria St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca A. Offer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Roland Offer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1902

8. AGE: Years	Months	Days	If less than one day
42	4	23	hr. min.

9. Birthplace Green Castle Pa
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

MOTHER / FATHER

12. Name Fred Miller

13. Birthplace Pa

14. Maiden Name Mary ?

15. Birthplace Pa

16 (a) Informant Roland Offer

(b) Address 104 Cambria St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Ct

Location a a Co Md

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W Montgomery St

JUN 21 1944 (Date filed by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to June 17 1944, and that I last saw her alive on June 17 19 44

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Bangels M. D.

Address Provident Hospital Date signed 6/20/44

G 18351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 S.Robinson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 S.Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Sentz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Sarah Nunemaker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 22, 1870

8. AGE: Years 74 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Tannetown Md.
(Town, county, and state)

10. Usual Occupation Carpenter Retired

11. Industry or business

FATHER
12. Name not known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Catherine Nunemaker
(b) Address 1114 S.Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 JUN 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1944, at 10.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1943, to June 17 1944, and that I last saw h.im alive on June 17 1944

Immediate cause of death: Arteriosclerosis C.V. Disease — Duration: 6-3-44

Due to: Myocardial Insufficiency

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Catherine Nunemaker M. D.

Address 822 S. Eutaw Ave Date signed 6-21-44

C 18352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

C 18352
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County A. A.
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mollie Snyder
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Max Snyder
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) May 15, 1884
8. AGE: Years 60 Months 1 Days 6 If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Home
MOTHER / FATHER
12. Name Samuel Findglass
13. Birthplace Russia
14. Maiden Name Rosie Finkeman
15. Birthplace Russia
16 (a) Informant Mr. Max Snyder
(b) Address 125 Cathedral St. Annapolis, Md.
17 (a) Burial (b) Date thereof June 22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kenilworth Israel
Location Annapolis, Md.
18 (a) Funeral director L. Hopkins
(b) Address Annapolis, Md.
19 JUN 21 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH June 21 1944, at 9:45 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1944 to June 21 1944, and that I last saw her alive on June 21 1944
Immediate cause of death Respiratory failure — Duration —
Due to Uremia — 2 months
Due to Hypertensive C.V. disease — Sev. months
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. Ellsworth Cole Jr. M. D.
Address Mercy Hospital Date signed June 4. '44

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

C 18353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

566 Registered No. C 18353

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 W. 31st Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Poe

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James V. Poe.
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) May 25 1894

8. AGE: Years	Months	Days	If less than one day
50		27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Harmany.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant James V. Poe.
(b) Address 1013 W 31st St

17 (a) Burial (b) Date thereof June 24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Harford Rd, Remington Md.

18 (a) Funeral director Arkinson & Donovan
(b) Address 615-17 Chestnut Ave.

19 (a) JUN 21 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 15
JUN 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 1:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1944, to June 21 1944, and that I last saw her alive on June 21 1944.

Immediate cause of death Pelvic peritonitis. — Duration 11 days

Due to

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation 6/10/44

Major findings of operation: Carcinoma of Cervix Uteri.

of autopsy Metastatic growth. Bronchopneumonia.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Q. Mitchell M.D.
M. D.

Address Md. Gen. Hosp. Date signed 6/21/44

G 18354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 18354 / 133a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Burgoon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Laura Burgoon.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name William Burgoon.
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Fmesk
15. Birthplace Maryland

16 (a) Informant Laura Burgoon
(b) Address Manchester, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24/44 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Md.

18 (a) Funeral director Jacob Wink + Sons
(b) Address Manchester Md

(Registrar) Huntington Williams, M.D.

JUN 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944, to June 21 1944, and that I last saw h.t.m. alive on June 21 1944

Immediate cause of death Uremia — Duration

Due to Chr. Pyelonephritis

Due to

Other Conditions Peri nephritic Abscess right

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ~~Above~~

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. V. Letumiyo M.D. M. D.

Address Univ. Hosp. Date signed 6-21-44

G 18355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√160c

Registered No. G 18355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5303 Plainfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Franz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/44

8. AGE: Years	Months	Days	If less than one day
			3 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Raymond Franz

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Dorothy Russell

15. Birthplace Balto., Md.

16 (a) Informant Hosp Records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 20 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 21 1944 (Date rec'd by registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 1944 to 6-19 1944, and that I last saw h[illegible] alive on 6-18 1944.

Immediate cause of death: Premature Separation of Placenta.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of building)
(e) Means of injury

23. Signature [illegible] Grossfeld

Address 5303 Plainfield Ave Date signed 6-19-44

VS 150

F 1026

G 18356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

Registered No. G 18356

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Mad Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town 1709 Madison
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Perkins

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/19-44

8. AGE: Years | Months | Days | If less than one day 19 hr. min.

9. Birthplace 1709 Madison
(Town, county, and state)

10. Usual Occupation No

11. Industry or business

FATHER 12. Name Matthews Wood
13. Birthplace Va

MOTHER 14. Maiden Name Maurene Porter
15. Birthplace Va

16 (a) Informant Maurene Porter
(b) Address 1709 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 21 1944 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1944 at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1944 to 6/20 1944 and that I last saw h[illegible] alive on 6/19 1944

Immediate cause of death
Pulm Diphtheria — Duration 19 hrs

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. J. Halpert M.D.
Address 1 Y W Pa Ave Date signed 6/20/44

1027

G 18357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G 18357 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. An incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Venable

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: James Venable
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1917

8. AGE: Years: 27 | Months | Days | If less than one day: hr. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Milton Shoemaker
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Mollie Flores
15. Birthplace: Penn.

16 (a) Informant: James Venable
(b) Address: Glenburnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/22/44 (month) (day) (year)
(c) Cemetery or crematory: Lutheran
Location: Lutherville Md

18 (a) Funeral director: Tillman & Doub
(b) Address: 1214 Eutaw St

19 (a) Date received by registrar: Huntington Williams, M.D.

JUN 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-20 1944, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1944 to 6-20 1944, and that I last saw her alive on 6-20 1944.

Immediate cause of death: Respiratory Ceased — Duration:
Due to: Rheumatic Heart Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: M. Rinehart M. D.
Address: University Hosp. Date signed: 6-20-44

G 18358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G 18358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Baton Rus.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agatha Patzkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1854

8. AGE: Years 89 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry

13. Birthplace Russia

MOTHER 14. Maiden Name Agatha Bnelcow

15. Birthplace Russia

16 (a) Informant Theresa Solins

(b) Address St Agnes Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)

(c) Cemetery or crematory Hillsboro Cem-

Location Hillsboro - Kan 323

18 (a) Funeral director George A. Nusbaum

(b) Address 4000 Old York Rd.

JUN 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1944, to 6-20 1944, and that I last saw h[illegible] alive on 6-20 1944.

Immediate cause of death: Cardio vascular disease
Cardiac failure — Duration

Due to:

Due to:

Other Conditions: Fracture neck right femur
(Include pregnancy within 3 months of death)

Date of operation 2-8-44

Major findings of operation: fracture neck rt. femur

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3/3/44 at home at M
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury: Slipped & fell to floor
(f) Signature Howard D. Steiner M. D.
Address St Agnes Hospital Date signed 6-20-44

Approved: Robert Lee Graham M.D. 6/26/44

G 18359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 18359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town Baltimore SPARROWS POINT
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Lodge Pl FORREST Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

6-5

3 (a) FULL NAME Mackey, Baby Boy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-44

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Harry E Mackey
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mabel
15. Birthplace New Orleans

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Gwynn Oak Ave

18 (a) Funeral director L Whitby Hunt Washington Mitchell Co.
(b) Address 4101 [illegible]

19 JUN 22 1944 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21-1944, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20-1944, to 6-21-1944, and that I last saw h[illegible] alive on 6-20-1944

Immediate cause of death Atelectasis of 1st Lung — Duration 2 days (since birth)

Due to prematurity, 8-12 mnths before term

Due to

Other Conditions (wt 2 lbs 9 3/4 oz)

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Harrison Lutz M. D.
Address Church Home & Hospital Date signed 6-21-44

18360 FICK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18360 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4850 Reisterstown Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4850 Reisterstown Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Fick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Charles F. Fick.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1863

8. AGE: Years	Months	Days	If less than one day
81	2	19	hr. min.

9. Birthplace Penna. Pa.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John H. Rhulz
13. Birthplace Pa

MOTHER
14. Maiden Name Martha Hale
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs L. M. Fick.
(b) Address 118 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Loring Byard.
(b) Address 500 Park Heights Ave.

19 (a) Filed [illegible] (b) [illegible] Registrar

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 16 1944 to JUNE 19 1944, and that I last saw h alive on 1944

Immediate cause of death	Duration
JUNE 19 Coronary Occlusion	3 da.
Due to Mitral Stenosis	6 mo
Due to	
Other Conditions Arterio Scler. OSIS, due to age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Sherman Wantz M. D.
Address 2601 Manhattan Ave Date signed 6/20/44

18361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G 18361 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Lakeland Sts.
(c) Hospital or institution W. B. D. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Keith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife Katherine Keith

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 18, 1944

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace W. B. D. H. Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lloyd Keith.
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Katherine Copley
15. Birthplace Balt. Md.

16 (a) Informant Lloyd J. Keith.
(b) Address 611 N. Bentalou St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof June 22 44 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

JUN 22 1944 (b) Registrar Williams, M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1944, at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18, 1944 to June 21, 1944, and that I last saw h.j.M alive on June 21, 1944

Immediate cause of death Intracranial Hemorrhage

Due to

Due to

Other Conditions Erb's Paralysis rt. arm.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Oscar Hartman M. D.

Address 1131 Eutaw Place Date signed 6/21/44

18362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18362
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Abbottston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Abbottston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret D. Gray

3 (b) If veteran, name war

3 (c) Social Security Account No. 207-01-5714

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas. A. Gray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1872

8. AGE: Years 72 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Accomac Co. Va
(Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Shirt Craft Co. Inc.

FATHER
12. Name David Wessell
13. Birthplace Va.

MOTHER
14. Maiden Name Nancy Ayers
15. Birthplace Va.

16 (a) Informant Miss Myrtle Gray
(b) Address 1617 Abbottston St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/24/44
(month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul st

19 (a) JUN 22 1944 (Date rec'd by registrar) (b) Thomas F. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 8 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 21, 1944

VS 161

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92d

Registered No. G 18363

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 E. Hoffman st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 E. Hoffman st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melchor Baker

3 (b) If veteran, name war: NN
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Mae E. Baker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 14th 1869
8. AGE: Years 75 | Months 4 | Days 7 | If less than one day hr. min.
9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name L. Baker
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry E. Baker
(b) Address 2601 E. Hoffman St.
17 (a) Burial (b) Date thereof 6/24/44
(Burial, ~~cremation~~, or ~~removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Black Rock
Location Butler Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 JUN 22 1944 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21st 1944, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1944 to June 21 1944 and that I last saw him alive on June 19 1944

Immediate cause of death: (a) Senilis anemia — Duration: 6 mo
Due to:
Due to:
Other Conditions: Chronic valv heart dis

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest D. Palmer M. D.
Address 734 Poplar St Date signed 6/21/44

18364
453893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5 54 G 18364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 S. Chester (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Rasinski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-9-24
8. AGE: Years 19 | Months 9 | Days 10 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Rasinski
13. Birthplace Prussia

MOTHER
14. Maiden Name Rose Nietubicz
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore
18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave
19 (a) (b) Registrar

JUN 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 10.30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944 to June 19 1944, and that I last saw him alive on June 19 1944.

Immediate cause of death	Duration
lymphosarcoma	7 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abraham Geneein M. D.
Address J.H.H. Date signed 6-20

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 b

Registered No. G 18365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Spray Ct.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Spray ct – (If rural give location)
(e) Citizen of foreign country? SPRAY (Yes or No)
If yes, name country

3 (a) FULL NAME Fidelia Dunton Avery Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mathews Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30 – 1902

8. AGE: Years 41 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Balt. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charles Dunton
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Jones
15. Birthplace Maryland

16 (a) Informant Mathews Davis (Husband)
(b) Address 1603 Spray Court –

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave

19 JUN 22 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1944, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1944, to 6/17 1944, and that I last saw h[illegible] alive on 6/15 1944.

Immediate cause of death Pulmonary T.B.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cara C. Johnson M. D.

Address 1502 Penna Ave Date signed 6/21/44

G 18356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

V G 18366

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt. Co
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 W 22nd St (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Flexner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Otto Flexner

13. Birthplace Vienna

MOTHER 14. Maiden Name Josephine Santzer

15. Birthplace Hungary

16 (a) Informant Dr. Flexner

(b) Address 1059 Amelia St. Chicago, Ill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (month) (day) (year)

(c) Cemetery or crematory Oheb Shalom

Location

18 (a) Funeral director Joseph Levin Inc

(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) (b) (Registrar)

JUN 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944 at 12 N.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944 to June 19 1944 and that I last saw h[illegible] alive on June 19 1944.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Carcinoma ?	
diabetes	
Due to	
Other Conditions Contin STS	

over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Luppitt M. D.

Address Union Memorial Hosp Date signed 6/19/44

G 18367 ✓ G 18367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Violet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Savage

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: 83 yrs | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Josel Getz
13. Birthplace Russia

MOTHER 14. Maiden Name Chaya Hannah
15. Birthplace Russia

16 (a) Informant Ben Savage
(b) Address 2112 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location

18 (a) Funeral director Jos Lauria Inc
(b) Address 1392 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 22 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 44 at 10:39 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 19 to June 20 19 44 and that I last saw her alive on June 2 19 44

Immediate cause of death: Acute Cardiac Dilatation — Duration 24 hrs

Due to: Chronic Myocarditis — Duration 3 yrs

Other Conditions: Arteriosclerosis — Duration 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M J Boylan M. D.

Address 2470 Eutaw Date signed 6/20/44

G 18368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 18368 Registered No.

PRINT IN PERMANENT BLACK INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME. SOPHIE GLAZER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband ~~or wife~~ Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia.

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Pulaski Highway & Bowleys Lane

18 (a) Funeral director Jaul & Levy Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by Registrar) JUN 22 1944 (b) Huntley Wilkinson Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21 1944, at 9:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1944 to 6-21 1944, and that I last saw her alive on 6-21 1944

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerotic Heart disease and Hypertension

~~Due to~~ Cardiovascular Lesions

Other Conditions Diabetes Mellitus Hyperthyroidism Arthritis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwerck M. D.
Address Sinai Hosp. Date signed 6-21-44

G 18369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 b

G 18369 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Howard Burton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Stumpf (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16 - 1882

8. AGE: Years: 62 | Months: 4 | Days: 4 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Baggage Room

11. Industry or business Grey Hound Bus Lines

FATHER
12. Name Robert Burton
13. Birthplace Md

MOTHER
14. Maiden Name Annie Esame
15. Birthplace Md

16 (a) Informant Mrs Julia Burton
(b) Address 119 N. Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)
(c) Cemetery or crematory Lawson Park
Location Pulaski Road

18 (a) Funeral director Lahey Sons
(b) Address 1248 Light St.

19 (a) JUN 22 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-20 1944, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 1944 to 6-20 1944, and that I last saw h/M alive on 6-20 1944

Immediate cause of death: Bronchial Pneumonia
Chronic Nephritis.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles R. McDaniel M. D.
Address 1213 Light St. Date signed 6-20-44

C 18370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

C 18370 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Castle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Digman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1944

8. AGE: Years	Months	Days	If less than one day
0	0	0	14 hr. 47 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Arthur Digman
13. Birthplace West Virginia

MOTHER
14. Maiden Name Dorothy Kreizinger
15. Birthplace Michigan

16 (a) Informant Mother – Dorothy Digman
(b) Address 220 N. Castle St. Balto. #13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-44 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Balto. Md.

18 (a) Funeral director Geo. A. Farley
(b) Address Fulton & Fayette St.

19 (a) JUN 22 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1944, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to June 21 1944, and that I last saw her alive on June 20 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity - 6 mos. gestation.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. E. Hornbrook M. D.
Address Mercy Hospital Date signed 6/22/44

BERGNER ✓

18371 BALTIMORE CITY HEALTH DEPARTMENT G 18371
CERTIFICATE OF DEATH 93N Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 W. North ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. North ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Bergner

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1874

8. AGE: Years 69 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Austria (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Wolf Bergner
13. Birthplace Austria

MOTHER 14. Maiden Name Esther M. Aldstadt Kayser
15. Birthplace Austria

16 (a) Informant Samuel W. Bergner
(b) Address 630 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North Ave

19 (a) (b) Huntington Williams, M.D.

JUN 22 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 3:45 p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1939, to June 21, 1944, and that I last saw him alive on June 10, 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 hr.

Due to Chronic Myocarditis — Duration 5 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emanuel Lewis M. D.
Address 601 N Broadway Date signed 6/21/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write correct age is especially important.

18372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G 18372

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Wilhelm St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Guest

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 213-05-9421

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife Minnie R. Guest

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) August 16 1897

8. AGE: Years 51 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Baltimore Transit Co

FATHER
12. Name William F Guest
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary E. Fowler
15. Birthplace Baltimore Md

16 (a) Informant Minnie L Guest
(b) Address 1809 Wilhelm St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Pott & Baum Walters
(b) Address Pratt & Stricker Sts

JUN 22 1944 (b) Hunter & Williamson
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944 at 5 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-1944 to 6-22-1944 and that I last saw h / alive on 6-21-1944

Immediate cause of death — Duration
Cardiac Dilatation — 12 hrs.
Due to Status Asthmaticus — 6 days
Due to Bronchial Asthma — 5-6 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Coleman Atkinson M. D.
Address 2424 Eutaw Place Date signed 6-22-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83N

G 18373 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1870 ELLicott Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 874 W Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** DANIEL T. GILLISS

3 (b) If veteran, name war NONE | 3 (c) Social Security Account No. NONE

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MATTIE E. GILLISS
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) JUNE 16. 1866

8. AGE: Years 78 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace CARROLL County Md (Town, county and state)

10. Usual Occupation RETIRED Boiler MAKER
11. Industry or business B & O R.R.

FATHER 12. Name John T. GILLISS
13. Birthplace Md

MOTHER 14. Maiden Name MARY E. HAINES
15. Birthplace Md

16 (a) Informant MATTIE E GILLISS
(b) Address 1870 ELLICOTT DRIVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 24 1944 (month) (day) (year)
(c) Cemetery or crematory MORGAN Chapel Cem
Location CARROLL County Md

18 (a) Funeral director R.C. & B.H. Walter
(b) Address PRATT & STRICKER Sts

19 (a) (Date received by Registrar) JUN 22 1944 Signature of Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20 1944 at 3 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to June 20 1944 and that I last saw him alive on June 20 1944

Immediate cause of death Cerebral Hemorrhage — Duration 1 week
Due to Arterial Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas A Parker M. D.
Address 2145 W Balto St Date signed

G 18374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 E Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 E Monument St (If rural give location)
(e) If foreign born, how long in U. S. A. Life years

3 (a) FULL NAME Matilda Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. 24705-4370

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1893

8. AGE: Years 51 | Months X | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Bohnes
15. Birthplace Washington D C.

16 (a) Informant Frederick Miller
(b) Address 3019 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Gaylord Ave Ext.

18 (a) Funeral director Frederick Miller Inc
(b) Address 3019 E. Monument St

19 (a) (Date received by Local Registrar) JUN 22 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21st 1944, at 3a M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1944, to 6/21 1944, and that I last saw her alive on 6/20 1944

Immediate cause of death: Carcinoma of Intestine — Duration: 1 yr

Due to:

Due to:

Other Conditions: Dropsy — 6 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma Intestine
Of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work? Y
(e) Means of injury X

23. Signature A. C. Hearn M. D.
Address 4901 Garrison Date signed 6/21/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1931 Registered No. G 18375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Harlan ave. Rear
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George (Khimath) Clemath

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant A. G. McLaughlan.
(b) Address 529 Washington Blvd

17 (a) Burial (b) Date thereof June 23 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location a a Co. Md.

18 (a) Funeral director Joseph Kaunakas
(b) Address 608 Washington Blvd

JUN 22 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19- 1944, at 11 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Chronic Myocardial degeneration. Hypertrophy. Dilation. Atherosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 6/19/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G 18376

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 W. Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Cuffey (Cuffie)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	C	Widowed

6 (b) Name of husband or wife Jeremiah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1898

8. AGE: Years	Months	Days	If less than one day
45	6	10	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Frank Robins on
13. Birthplace S.C.

MOTHER
14. Maiden Name Amanda
15. Birthplace S.C.

16 (a) Informant Irene Arnold (Cousin)
(b) Address 636 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

JUN 22 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th, 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/08/44 to 6/18/44, and that I last saw [illegible] alive on 6/18/44.

Immediate cause of death (a) Uremia
Due to (b) Fractured hip
Due to (c) Senile arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

6379

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Cecil Ellis M. D.
Address 974 Hart Co Date signed 6/20/44

305651 G 18377.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130c

G 18377
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town 1706 Mulberry Pl.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Irene Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race Blk
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alexander W. Jones
6 (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) 3-7-10
8. AGE: Years 34 Months 3 Days 11 If less than one day ____ hr. ____ min.
9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation H. wf
11. Industry or business

FATHER
12. Name William Ryan
13. Birthplace Baltimore Lyles Md.

MOTHER
14. Maiden Name Bessie Lyles
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 22, 1944
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Western Star
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 6/22/44 Herbert Williams M.D.
(Registered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12- 1944, to 6-18- 1944, and that I last saw h[illegible] alive on 6-18- 1944.

	Duration
Immediate cause of death ATELECTASIS AND TERMINAL BRONCHOPNEUMONIA	24 hrs.
Due to SYPHILITIC CORD DISEASE WITH QUADRIPLEGIA	5 mos.
Due to GUMMATA OF 4th LUMBAR VERT AND RT. 1st RIB	12 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: X
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward E. Baumann M.D.
Address Johns Hopkins Hosp. Date signed 6/19/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 10378

1186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town 4203 Springdale Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leon Bosley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 - 1878

8. AGE: Years 65 | Months 5 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Harford Co. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hiram Coburn
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Lillie Cox
15. Birthplace Harford Co Md

16. (a) Informant Leon Bosley
(b) Address Hyde Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22.44 (month) (day) (year)
(c) Cemetery or crematory Grove Cem. Location Aberdeen Md.

18 (a) Funeral director Clarence E. Cullum
(b) Address Forth Md.

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20/44 19 ... at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3/44 19 ... to 6/20/44 ... and that I last saw h[illegible] alive on 6/18/44

Immediate cause of death Arteriosclerotic Heart Disease — Duration 1

Due to ... — Duration ...

Due to ... — Duration ...

Other Conditions Fractured Femur — Duration 8 mos.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ...

of autopsy: 105

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence March 9 1944 M
(c) Where did injury occur? Ford (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no
(Specify type of place)
(e) Means of injury Fell to floor

23. Signature Jacob A. Morgan M. D.
Address 6 E. Pleasant St. Date signed 6/21/44

Approved by Howard J. Andelis, M.D.

G 18379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314 G 18379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 845 China ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 845 China ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Gross.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married -

6 (b) Name of husband or wife John Gross
6 (c) If alive, give age 58/~~59~~

7. Birth date of deceased (mo., day, yr.) July - 7 ~~1885~~

8. AGE: Years	Months	Days	If less than one day
49 ~~58~~	11	17	hr. min.

9. Birthplace Kent Island - Md - (Town, county, and state)
10. Usual Occupation Home —
11. Industry or business

FATHER
12. Name Noah. Brown
13. Birthplace Md -

MOTHER
14. Maiden Name Amelia Baynard -
15. Birthplace Md -

16 (a) Informant Hattie Brown
(b) Address 837 China ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaiah Brown Son
(b) Address 108 W Montgomery Street

19 (a) 6/22/44 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 19 1944, at 7.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 20 19 44 to June 19 19 44 and that I last saw h alive on June 19 19 44

Immediate cause of death Cerebral Hemmorhage

Duration
1 mo.

Due to Hypertension

Due to Nephritis -

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Svamden M. D.

Address 1711 Lee Date signed 6/21/44

(OVER)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. C 18380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 260 S. Durham Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 260 S. Durham St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Jungelewicz Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1872

8. AGE: Years	Months	Days	If less than one day
72	4	4	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Cabinet Maker.

FATHER
12. Name Vincent Jungelewicz
13. Birthplace Poland

MOTHER
14. Maiden Name Petronela ?
15. Birthplace Poland

16 (a) Informant Mr. Frank Jungelewicz Sr.
(b) Address 260 S. Durham St

17 (a) Burial (b) Date thereof June 23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Welby
(b) Address 407 S. Chester Street

(a) JUN 22 1944 (b) Huntington Williams
Date rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 1.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944, to June 20 1944, and that I last saw deceased alive on June 20 1944

Immediate cause of death: Carcinoma of Lungs metastasis to Liver — Duration 6 mos.
Due to
Due to
Other Conditions: Total Blindness due to Cataract — 8 Yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas L. Deweese M. D.
Address 200 E. Pratt Date signed 6/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 18351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1109 Shields place

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1109 Shields Pl. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Martha Va. Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace West River Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Osborne Harris

13. Birthplace Md

MOTHER 14. Maiden Name Phillis Harris

15. Birthplace Md

16 (a) Informant Beth Hill (niece)

(b) Address 1306 n Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Mt Winans

18 (a) Funeral director E Vroy Owens

(b) Address 000 Plantlerya

19 (a) 6-23-1944 (b) Huntington Williams, M.D. Address 1306 Druid Hill Ave Date signed

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1944 to 6/21 1944, and that I last saw her alive on 6/20 1944

Immediate cause of death: Cerebral Apoplexy (8) — Duration

Due to: Senility

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Burkett M. D.

G 18382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1934

G 18382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light st.
(c) Hospital or institution: South East. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Thompson (Johnson)
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-12-1911
4. Sex FEMALE
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9 | 28 | 1857
8. AGE: Years 76 | Months 8 | Days 23 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Tavern
FATHER 12. Name Samuel Johnson
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Mary [illegible] Lochmay
15. Birthplace Hamburg Germany
16 (a) Informant John W. Thompson
(b) Address 2904 Edison Highway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/34 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave
18 (a) Funeral director Elizabeth Funk Inc
(b) Address 115 East Fort Ave.
19 (a) Date received 6-29-1934 (Registrar) Emily Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21 1934, at 3:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1934 to 6-21 1934, and that I last saw h[illegible] alive on 6-21 1934.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George Brooks Wilson M. D.
Address South East. Gen. Date signed 6-21-34

VS 180

For O R.L. Graham, Dr Howard J. Malden, M.D.

C 18383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8V

C 18383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6303 Windsor Mill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley William Naumann

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-6987

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-24-1908

8. AGE: Years 35 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Alberton, Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Balto. Co. Pumping Station

FATHER
12. Name William C. Naumann
13. Birthplace Virginia

MOTHER
14. Maiden Name Pearl Speicher
15. Birthplace Virginia

16 (a) Informant Mrs. Wilson Plumley Jr.
(b) Address 6303 Windsor Mill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Elliott City

18 (a) Funeral director H. Hilgenbrinck & Son
(b) Address Ellicott City, Md.

19 (a) (Date received by Registrar) JUN 22 1944 Thursday Dr. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21- 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Abscess, spinal cord.

Due to

Other Conditions Acute Pleurisy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 6-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

C 18384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

C 18384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 Pelham Ave.
(c) Hospital or institution: 8 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Pelham Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Wurzbacher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Conrad H. Wurzbacher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9.1857

8. AGE: Years	Months	Days	If less than one day
87	2	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Seidel
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Schmiller
15. Birthplace Germany

16 (a) Informant Miss Amelia Wurzbacher
(b) Address 2403 Pelham Ave.

17 (a) Burial (b) Date thereof 6/25/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Immanuel Cemetery
Location Loco Baltimore, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) Huntington Williams, M.D. Registrar
(Date received) (Registrar)
JUN 22 1944

MEDICAL CERTIFICATION P

20. DATE OF DEATH June 21st. 1944 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 6/21 1944 and that I last saw h[illegible] alive on 6/21 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. W. Gilley M. D.
Address 5763 Harford Rd Date signed 6/22/44

18335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. C 18385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Aisquith St.
(c) Hospital or institution: Hebrew Friendly Inn
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 117½ N. Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WEBSTER KING

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: ########
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-1887

8. AGE: Years 57 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Prince Frederick Md (town, county, and state)
10. Usual Occupation Caretaker
11. Industry or business Hebrew Friendly Inn

FATHER
12. Name James T. King
13. Birthplace prince Frederick. Md

MOTHER
14. Maiden Name Annie Hardaty
15. Birthplace Prince Frederick, Md.

16 (a) Informant Mr. Isador B. Terrell
(b) Address 1301 Tower Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address North Ave & Broadway

JUN 22 1944 (Date rec'd by registrar)
(b) Hinkley for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1943, to June 12 1944, and that I last saw him alive on June 12 1944.

Immediate cause of death: Pulmonary Hemorrhage — Duration

Due to: Probable malignancy of lung. —

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris G. Dorf M. D.
Address 11 E Biddle St Date signed 6/22/44

For R. H. B. McNally, by Hinkley & Williams, M.D.

G 18386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1621 G 18386

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Augusta St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Woolf (Lena Wolf)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Germany (town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Germany.

16 (a) Informant Reverend. George Foerster
(b) Address 1225 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd & Belle Ave

18 (a) Funeral director George A. Ruth Inc.
(b) Address 1745 Bluefield Ave.

JUN 22 1944 (Date received by registrar)

(b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 12 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8-44 to 6-20 1944, and that I last saw her alive on 6-20 1944.

Immediate cause of death Malnutrition & cachexia — Duration

Due to

Due to over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 6-20-44

G 18382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18382 V48C Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 East St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 East St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Henderson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1884

8. AGE: Years 60 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Henderson
(b) Address 430 East St 6/22/44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1900 Pennsylvania Ave
Huntington Williams, M.D.

19 (a) (Signature of Registrar) Registrar

JUN 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 19XX, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4, 19XX, to June 15, 19XX, and that I last saw h[illegible] alive on June 14, 19XX.

Immediate cause of death Cancer of uterus — Duration ?

Due to

Due to

Other Conditions Hypertension

(If made pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd St Date signed 6-20-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Use figures for dates. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G 18388

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Dietz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Washington D. Dietz
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 7, 1877

8. AGE: Years 67 | Months 1 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name (?) Osborn
13. Birthplace Md

MOTHER
14. Maiden Name Clementine (?)
15. Birthplace Md

16 (a) Informant Washington D. Dietz
(b) Address 1614 Light St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md

18 (a) Funeral director G. Howard Evans
(b) Address 1400 St. Paul St. Balto. (30)

(Date rec'd by registrar) JUN 23 1944 (b) Registrar Thurlow W. Williams, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1944 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 21 1944 that I last saw him alive on June 19 1944.

Immediate cause of death: Eclampsia — Duration: 2 days
Due to: Placental Hemorrhage — 3 Weeks
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Nature of injury
23. Signature R. K. Campbell M. D.
Address 1644 Hanover Date signed 6/22/44

G 18389 ✓ G 18389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 E. Chase (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Edwin C. Holden

3 (b) If veteran, name war .....
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace M.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1872

8. AGE: Years	Months	Days	If less than one day
71	7	13	..... hr. ..... min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Mining Engineer
11. Industry or business Davis Chemical Co.

FATHER
12. Name Albert J. Holden
13. Birthplace N.Y.

MOTHER
14. Maiden Name Henrietta Lambert
15. Birthplace N.Y.

16 (a) Informant Mrs. Grace Holden
(b) Address 202 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 1944 (month) (day) (year)
(c) Cemetery or crematory Kensico
Location Mt. Pleasant, N.Y.

18 (a) Funeral director Wm. Ahl Inc.
(b) Address 10 East Preston

JUN 23 1944 (b) Huntington Station, N.Y.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944 at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-1940 to 6-21-1944 and that I last saw him alive on 6-17-1944.

Immediate cause of death Cerebral hemorrhage — Duration Symptoms three days

Due to Cerebral arteriosclerosis and hypertension (230-130) — Duration present more than 4 years

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Richard N. Tallman M. D.
Address 3035 St. Paul St Date signed 6-22-44

G 18390 ✓ G 18390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Seventh Ballo Fire Hdqrs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 W. Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Edgar CANNON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Lillie G. Cannon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd 1876

8. AGE: Years 68 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Gas & Electric Co

FATHER
12. Name Capt. Richard Cannon
13. Birthplace Md

MOTHER
14. Maiden Name Annie E. Travers
15. Birthplace Md.

16 (a) Informant Mrs. Delma Tarbutton
(b) Address 605 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location Woodlawn Md

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) [illegible] (By registrar) [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19YY, at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 19YY to 6/21 19YY and that I last saw h~~im~~live on 6/21 19YY

Immediate cause of death: Coronary occlusion — Duration 3 hrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Lukats, M.D.
Address 1213 Light St. Date signed 6/21/44

180

G 18391

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G 18391

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 N. Calvert st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy M. Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~ Irving Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1863

8. AGE: Years 81 | Months 4 | Days 9 | If less than one day hr. min. 10

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Unknown) Yelland
13. Birthplace England

MOTHER
14. Maiden Name Margaret Smardan
15. Birthplace England

16 (a) Informant Dr Irving Miller
(b) Address 1211 N. Calvert st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) JUN 23 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22nd 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944, to June 22 1944, and that I last saw h~~e~~r alive on June 21 1944.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to Coronary artery sclerosis	
Due to Generalized arteriosclerosis symptomless	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place Date signed 6-23-44

G 18392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X V 159

G 18392 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. & H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-6
(e) Length of stay in Baltimore (yrs., mos., or days) (John)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Elmridge Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Black

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1944

8. AGE: Years	Months	Days	If less than one day
			9 hr. 30 min.

9. Birthplace W. B. & H. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name Harvey Ross Black, Jr.
FATHER 13. Birthplace Hanover, Pa.
MOTHER 14. Maiden Name Mary Dorothy Heil
MOTHER 15. Birthplace Balt. Md.

16 (a) Informant H. Ross Black Jr.
(b) Address 1204 Elmridge Rd

17 (a) Burial (b) Date thereof June 23 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Robt S. Little
(b) Address 3700 Edmondson Ave

19 JUN 23 1944 (b) (Date rec'd by registrar) Hartley [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 9 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944, to June 21 1944, and that I last saw HIM alive on June 21 1944

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reed W Bachman M. D.
Address West Baltimore General Ho Date signed 6-22-44

G 18393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

✓ G 18393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Barclay st - Rear
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cesear Whetstone

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 - 1889

8. AGE: Years	Months	Days	If less than one day
54	7	0	hr. min.

9. Birthplace Manheim Penn
(Town, county, and state)
10. Usual Occupation Rail Road
11. Industry or business

FATHER
12. Name David K Whetstone
13. Birthplace Penn

MOTHER
14. Maiden Name Orphe Wiehl
15. Birthplace Penn

16 (a) Informant Mrs W Whetstone wife
(b) Address Bedford Penn

17 (a) Burial (b) Date thereof June 25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bedford Penn
Location
18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

JUN 23 1944 (b) Huntingdon Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22 - 1944, at 2.20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation, mechanical
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-22 at 1.15 A.M.
(b) Where did injury occur? 1721 Barclay St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Misadventure on neck

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 6-22-44

18394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 18394
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 & 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Westwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lena White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Peter White
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 6. 1902

8. AGE: Years	Months	Days	If less than one day
41 yrs	8	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic work -
11. Industry or business

MOTHER / FATHER
12. Name Robert Worell
13. Birthplace Virginia
14. Maiden Name Nellie Johnson
15. Birthplace Virginia

16 (a) Informant Peter White
(b) Address 1729 Westwood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Lee H. Kilson
(b) Address 1303 Pressman St

19 (a) (b)

JUN 29 1944
VS 150

Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 6.A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to June 20 1944, and that I last saw her alive on June 18 1944.

Immediate cause of death	Duration
Coronary Heart Disease	1 mo
Due to Hypertensive Cardiac Disease.	2 yrs -
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. S. Julian Jr. M. D.
Address 911 N. Salvador St. Date signed 6/30/44

G 18395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 18395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Laurens St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Wallie Contee

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-9559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1904

8. AGE: Years	Months	Days	If less than one day
40	3	17	...hr. ...min.

9. Birthplace Calvert Md (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Wesley Contee
13. Birthplace Md

MOTHER
14. Maiden Name Madora Jones
15. Birthplace Md

16 (a) Informant Ada Holloway
(b) Address 1840 Mosher St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-44 (month) (day) (year)
(c) Cemetery or crematory Halls Creek
Location Calvert Co

18 (a) Funeral director Primas & Sewell
(b) Address Prince Frederick Md

19 JUN 23 1944 (Registrar) [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 9 30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Prin death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of spleen; Hemorrhage into abdominal cavity

Due to.....

Other Conditions Tuberculosis of adrenals and left kidney (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury June 20, 1944 M.
(b) Where did injury occur Cattman Pike, Cal Co
(c) Did injury occur at home, on farm, industrial place, in public place? In automobile While at work? Yes
(d) Means of injury Tripped & fell

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 21, 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 18396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Moravia Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Moravia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM C. HEUSLER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: 212-09-0225

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charlotte C. Heusler
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1890

8. AGE: Years: 54 | Months: 0 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Accountant
11. Industry or business: Standard Oil Co.

FATHER
12. Name: Charles E. Heusler
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Louise F. Lutz
15. Birthplace: Baltimore Co., Md.

16 (a) Informant: Howard S. Heusler
(b) Address: 3403 Richmond Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/24/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2006 Orleans St.,

19 (a) JUN 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1944 at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1939, to June 20, 1944 and that I last saw h alive on 19

Immediate cause of death: Hemiplegia — Duration:

Due to: Hypertension

Due to: Cardio-renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature] M. D.
Address 1123 St. Paul St Date signed 6-22-44

G 18392 Rode ✓ G 18397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 E Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Rode

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-3984

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura Rode
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Mar 17 1889

8. AGE: Years 54 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Tinner

11. Industry or business

FATHER
12. Name Frances Rode
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret McAllister
15. Birthplace Baltimore

16 (a) Informant Laura Rode
(b) Address 1929 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) JUN 23 1944 Huntington W Va Registrar
(Local registrar) (b) (State)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1944 at 9 P.M. KS

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 19 44 to 6/20 19 ; and that I last saw him alive on 6/20 19 44

Immediate cause of death Cardio respiratory failure — Duration

Due to Pericardial Effusion

Due to Carcinoma of Prostate

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Prostate

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold R. Pinco M. D.
Address Irvin Hosp - Date signed 6/22

C 18398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C 18398 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 13 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Druid Hill (Exact residence or location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luther Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Iva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23 1895

8. AGE: Years 49 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county and state)

10. Usual Occupation Chauffeur
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Iva Smith
(b) Address 2505 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Ed. Holland
(b) Address 1631 Druid Hill Ave.

JUN 23 1944 (Date rec'd by registrar)

(b) Registrar

VS 150

MEDICAL CERTIFICATION 45

20. DATE OF DEATH June 18 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944, to June 18 1944, and that I last saw him alive on June 18 1944.

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to: Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. H. Barnes
Address Provident Hospital Date signed M. 6 D. 23 44

G 18399

G 18399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1441

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ~ Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name county)
(d) Street No. 1847 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

00454

3 (a) FULL NAME Lucille Bailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race Colored | 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leroy R.

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 34 | Months | Days | If less than one day min.

9. Birthplace Balto. Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Richard Shields
13. Birthplace Balto. Md.

MOTHER: 14. Maiden Name Cora Harris
15. Birthplace Balto. Md.

16 (a) Informant Leroy R. Bailey
(b) Address 1847 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-44 (month) (day) (year)
(c) Cemetery or crematory Carlton Memorial Park
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Carl A. Stafford
(b) Address 1847 Druid Hill Ave.

JUN 23 1944 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1944 to June 18 1944, and that I last saw h[illegible] alive on June 18 1944.

Immediate cause of death: Acute Pulmonary Edema

Due to Toxemia of Pregnancy

Due to [illegible]

Other Conditions Chronic Interstitial Nephritis; Pulmonary Tuberculosis (Inactive)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 day
3 weeks

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Ramsay, M.D.
Address 426 Eutaw St. Date signed 6/23/44

VS 150

18400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

G 18400 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 W. Baltimore
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Kernan

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20. 1944

8. AGE: Years	Months	Days	If less than one day
0	-	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name W. Stewart Kernan
13. Birthplace Baltimore. Md.

MOTHER
14. Maiden Name Helen Schultz
15. Birthplace Md.

16 (a) Informant W. Stuart Kernan
(b) Address 2127 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave.

19 JUN 23 1944 (Date rec'd by Registrar) (b) H. Taylor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944, to June 22 1944 and that I last saw him alive on June 22 1944

Immediate cause of death Cerebral Hemorrhage — Duration 48 hrs.
Due to
Due to
Other Conditions Partial Atelectasis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Worthy Jr. M. D.
Address 3 E. Seventh St. Date signed 6/24/44

VS 3

G 18401 — BALTIMORE CITY HEALTH DEPARTMENT — G 18401

AB-62884

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs-5mos-1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 W. Lanvalle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maria Anthony

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife John (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-6-1863

8. AGE: Years	Months	Days	If less than one day
81	-	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Proctter
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Marshall
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 JUN 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21- 1944, at 10PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1941, to 6-21 1944, and that I last saw h[illegible] alive on 6-21 1944

Immediate cause of death	Duration
(a) Cardiac failure	7
Due to (b) Arterio Sclerotic Heart Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattner M.D.
Address B.C.H. Date signed 6/22/44

G 18402

T.G.P.-88563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 18402 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Mace Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carter Paul — Paul Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Separated

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1904

8. AGE: Years	Months	Days	If less than one day
40	3	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis Carter (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Eliza Howard
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Signature of local registrar) (b)

JUN 23 1944

MEDICAL CERTIFICATION

A

20. DATE OF DEATH June 22 1944, at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1944 to 6-22 1944 and that I last saw h[illegible] alive on 6-22 1944.

Immediate cause of death: Pulmonary Embolism — Duration: Hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathews

Address B.C.H. Date signed 6/22/44 (M.D.)

G 18403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 18403 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3545 Keswick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRIETTA LEACH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Elias F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1861

8. AGE: Years	Months	Days	If less than one day
82	10	9	hr. min.

9. Birthplace Front Royal, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Henry
13. Birthplace Va.

MOTHER
14. Maiden Name -- Scroggins
15. Birthplace Va.

16 (a) Informant Mr. Earl E. Leach
(b) Address 3545 Keswick Rd. 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 23 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1944, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941, to June 22 1944, and that I last saw h[illegible] alive on June 21 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	10 hr.
Due to: Chronic Nephritis	3 yrs.
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 3655 — Date signed 6/22/44

G 18404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank F. Schad

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19 - 188[illegible]

8. AGE: Years	Months	Days	If less than one day
62	5	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Tax Appeal Court

FATHER
12. Name Henry Schad
13. Birthplace Frankford, Germany

MOTHER
14. Maiden Name Emma A. Jaeger
15. Birthplace Saxony, Germany

16 (a) Informant Mr. Henry Schad
(b) Address 406 Dixie Drive, Towson

17 (a) Burial (b) Date thereof 6/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 23 1944 (Date received by Registrar) Howard W. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22- 1944, at 11 45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 6-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 18405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 So Edew St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 106 So Edew St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Behjou

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Wolf

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER
12. Name Meyer Flashner
13. Birthplace Austria
14. Maiden Name Gettle
15. Birthplace Austria

16 (a) Informant Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23-44 (month) (day) (year)
(c) Cemetery or crematory Montgomery and Co
Location German Hill Rd

18 (a) Funeral director Jack Levy Inc
(b) Address 1437 E Baltimore St

JUN 23 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22- 1944 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept- 1940 to June-22-1944, and that I last saw h[illegible] alive on June-22-1944.

Immediate cause of death Uremia — Duration about

Due to Chronic Nephritis — Duration 12 yrs

Due to Hypertension — Duration

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Seidel M. D.
Address 2404 Eutaw Pl Date signed 6/22/44

VS 180

G 18406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G 18406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3912 Third Street
(c) Hospital or institution: Balto 25 Md. 25 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Third St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Talbott Resau

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie Resau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 15

8. AGE: Years 73 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Elkridge Md (Town, county, and state)

10. Usual Occupation Engineer retired

11. Industry or business B & O R R

FATHER: 12. Name John H Resau
13. Birthplace Elkridge Md

MOTHER: 14. Maiden Name Mary Talbott
15. Birthplace Elkridge Md

16 (a) Informant Mrs Mattie Resau
(b) Address 3912 Third Street Baltimore 25 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 -44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location A A Baltimore County Md

18 (a) Funeral director Matthew Schellenger
(b) Address 3914 S Hanover Street

19 (a) (Date received by local registrar) (b) Registrar

JUN 23 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1943 to June 22 1944, and that I last saw him alive on June 20 1944.

Immediate cause of death	Duration
1870 Coronary thrombosis	
Due to	
Due to	
Other Conditions Hypertension Cerebral sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Ralph Ave Date signed

G 18403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

G 18403 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132 N. Lanvale
(c) Hospital or institution: Nursing Home 1421
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 year
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No). If yes, name country

3 (a) **FULL NAME** Mrs Jennie Nicholson Browne

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20-1876

8. AGE: Years 68 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. md (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Mr Bernard Browne
13. Birthplace Queen Anne's Co md

MOTHER
14. Maiden Name Jennie Nicholson
15. Birthplace Balto md

16 (a) Informant Mrs Mary M. Browne
(b) Address 1505 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry M. Jenkins Sons
(b) Address McCulloh & Orchard Sts.

JUN 23 1944 (Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10, 1943 to June 21 1944 and that I last saw her alive on June 21 1944

Immediate cause of death	Duration
Coronary occlusion	1 hr.
Due to Cerebral hemorrhage	5 yrs
Due to Arterio-sclerosis	5 yrs
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Tapman Shamer M. D.
Address 3300 W. North Ave. Date signed June 23 1944

G 18408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18408 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Berea & Fairmount Ave.
(c) Hospital or institution: Church Home & Hosp. 9-44
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town ~~Balto~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Mathew St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cora Kaufmann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife Nat. L. Kaufmann
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1870

8. AGE: Years 73 7 mos Months 7 Days 5 If less than one day hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation none
11. Industry or business —

FATHER
12. Name B. Woodrow
13. Birthplace Penna.

MOTHER
14. Maiden Name E. Norris
15. Birthplace Penna.

16 (a) Informant Mrs. Margaret Hyjin
(b) Address 2901 Mathew St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Wendell C. Humphreys
(b) Address [illegible] Broadway, Balto, Md.

JUN 23 1944 (Date rec'd by Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at 4.55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944, to June 20 1944, and that I last saw h[illegible] alive on June 20 1944.

Immediate cause of death	Duration
Terminal bronchopneumonia	
Due to fractures of humerus fracture of femur	
Due to	
Other Conditions diabetes, arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation May 27, 1944
Major findings of operation: fracture left femur & left humerus
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 9/4
(b) Date of occurrence 5-24-44 at [illegible] P. M
(c) Where did injury occur? 2901 Mathew (City or town) Street (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down 2 steps at home.

23. Signature Charles Strand Natchi M. D.
Address C.H.H. Date signed 6/22/44

For D.R.L. Bodman by Howard J. Madden M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVED FOR BINDING

G 18409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18409 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 W. Mt. Royal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Helicus

3 (b) If veteran, name war —

3 (c) Social Security Account No. N.Y. 125-07-0873

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1914

8. AGE: Years 30 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace South Jewett N.Y. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Oliver Helicus
13. Birthplace Brattleboro, N.Y.

MOTHER
14. Maiden Name Sarah Glace
15. Birthplace Lexington N.Y.

16 (a) Informant Sarah Glace Helicus
(b) Address Jewett, New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-44 (month) (day) (year)
(c) Cemetery or crematory Maplewood Cemetery
Location Jewett N.Y.

18 (a) Funeral director A. Lee Adler
(b) Address 4644 York Rd.

19 (a) [illegible] Registrar

JUN 23 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing injuries of chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury June 22, 1944 11/2 M.
(b) Where did injury occur? Rear of 1419 N. Charles St
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? Yes
(d) Means of injury Auto fell off jack onto deceased

23. Signature John L. Gelston M.D.
Medical Examiner.
Date signed June 23, 1944

...CERTIFICATE WHILE LEAVEL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18410 V G 18410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1003

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Edward W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1891

8. AGE: Years	Months	Days	If less than one day
52	7	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Callendar
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura Martin
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. M. D. Weber
(b) Address 1702 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

JUN 27 1944

(Registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 8:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7 1944, to 6-22 1944, and that I last saw her alive on 6-21 1944.

Immediate cause of death	Duration
Pulmonary infarction (Rt side) with pleural effusion	
Due to Thrombophlebitis	
Due to	
Other Conditions Stricture of common bile duct with jaundice	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Bayman M. D.
Address St. Joseph Hospital Date signed 6-22-44

G 18411 ✓ G 18413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Fait Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 (6 ?)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes A. Hugel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1889

8. AGE: Years 55 | Months 4 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robert Ompteda
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Stecker
15. Birthplace Baltimore, Md.

16 (a) Informant Frank Hugel
(b) Address 3202 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
Address 1639 N. Broadway

JUN 23 1944 (b) ..... M.
(Date rec'd by reg. (b) ..... M.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1944, at 2 30 A M

21. I certify that I took charge of the remains described above, held an Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio sclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ralph B. McNally M.D.
Medical Examiner.
Date signed 6/26/44.

G 18412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18412 Registered No. 467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1741 BANK ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1741 BANK ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK L. CASHMYER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:
4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN. 17 1881
8. AGE: Years 63 | Months 5 | Days 4 | If less than one day: hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business BUTLER BROTHERS
FATHER 12. Name HENRY CASHMYER
13. Birthplace GERMANY
MOTHER 14. Maiden Name MARY E. ZINKAND
15. Birthplace Clem Co. BALTO. MD.
16 (a) Informant MARY E. CASHMYER (SISTER)
(b) Address 1741 BANK ST.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 26/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD
18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE
(c) JUN 23 1944 (Filed by registrar) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JUNE 21 1944 at 11/30
21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to June 21 1944 and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary thrombosis
Due to: arteriosclerosis
Due to:
Other Conditions: Generalized
(Include pregnancy within 3 months of death)

Duration: 2 mos. from Onset

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Grace L. Stemples M. D.
Address 700 N. Bath St. Date signed 6/24/44

VS 150

C 18413 ✓ C 18413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST. JOSEPH HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 DAS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE DAS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 SINCLAIR LANE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Mary Champness
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 20 1902

8. AGE: Years	Months	Days	If less than one day
42	3	1	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ROBERT CHAMPNESS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ANNA GOEB
15. Birthplace BALTO. MD.

16 (c) Informant ROBERT CHAMPNESS (FATHER)
(b) Address 2135 SINCLAIR LANE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 24/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeller Sons
(b) Address 403 S[illegible] ST.

19 (a) JUN 23 1944 by registrar (b) [illegible] Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1944 to 6-21 1944 and that I last saw h[illegible] alive on 6-20 1944

Immediate cause of death	Duration
Asphyxia	
Due to Bronchogenic Carcinoma of Lung.	
Due to	
Other Conditions Spread to mediastenum Kidneys & Liver. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy Ca of lung & metastases [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St. Joseph Hospital Date signed 6-21-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. C 18414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Bauer (BAUER)
3 (b) If veteran; name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret B. Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28 - 1881

8. AGE: Years	Months	Days	If less than one day
62	6	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business

FATHER
12. Name George Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Frederick
15. Birthplace Germany

16 (a) Informant Margaret B. Bauer
(b) Address 114 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Joppa Ave.

18 (a) Funeral director Otto G. Miller
(b) Address 2334 Jefferson St.

19 (a) JUN 23 1944 (Registrar) [signature] Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21/1944 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1944 to 6/21 1944, and that I last saw her alive on 6/17 1944.

Immediate cause of death	Duration
Circulatory Failure - Liver Insufficiency -	
Due to Carcinoma of Liver Metastasis.	
Due to	
Other Conditions Metastasis to Mediastinum - Jaundice	

(Include pregnancy within 3 months of death)

Date of operation 6/15/44

Major findings of operation: Carcinoma at liver.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Wallace

Address 1400 N. Carolina St. Date signed 6/21/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

456278 G 18415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 74a G 18415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town OMAR
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorene Balentine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13. 1941

8. AGE: Years	Months	Days	If less than one day
3	4	9	hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Everett Balentine
13. Birthplace W Va

MOTHER 14. Maiden Name Georgie Perri
15. Birthplace W. Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 26 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Creek Cem.
Location Omar, W. Virginia

18 (a) Funeral director Wendell Klumpel
(b) Address 3125 Edmondson Ave.

19 (a) (b)
(Date rec'd by registrar)

JUN 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 920 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944, to June 22 1944, and that I last saw her alive on June 22 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Septicemia	6 days
Due to Acute lymphoid leucemia	1 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Jay Dacon M.D.
Address Johns Hopkins Hosp. Date signed 6-22-44

G 18416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 18416

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Shutter ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Shutter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Williams Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1907

8. AGE: Years 36 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Keyesville, Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Williams, Jr.

FATHER 13. Birthplace Va.

MOTHER 14. Maiden Name Jane West

MOTHER 15. Birthplace Va

16 (a) Informant Wilton Frazier

(b) Address 1603 Ellsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co.

18 (a) Funeral director Rayner Sanders

(b) Address 1462 E. Preston St

19 (a) JUN 23 1944 (Date filed by registrar) (b) Registrar

JUN 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944 to June 20 1944, and that I last saw h alive on June 20 1944

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edw. Fisher M. D.

Address 1462 E Monument Date signed June 21 1944

G 18412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 18412

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1938 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian L. Harpold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charled H. Harpold
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) February 2, 1884

8. AGE: Years	Months	Days	If less than one day
60	4	21	hr. min.

9. Birthplace Cottageville, Jackson Co., W.Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Ellahugh Blair
13. Birthplace Virginia

MOTHER
14. Maiden Name Miss Dulin
15. Birthplace West Virginia

16 (a) Informant Mr. Charles H. Harpold
(b) Address 1938 Edmondson Ave.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof June 24 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn, Md.
Location

18 (a) Funeral director Wells Lamoreau
(b) Address 1005 W. Baltimore St.

19 JUN 24 1944 [illegible]
Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944, at 1.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944, to 22, 1944, and that I last saw her alive on June 22 1944

Immediate cause of death Coronary occlusion

Due to Thrombus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1959 Edmondson Ave Date signed

G 18418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G 18418

VA-88484

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Lucas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1883

8. AGE: Years	Months	Days	If less than one day
61	2	27	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Tom Lucas (deceased)
13. Birthplace Russia

MOTHER
14. Maiden Name Annie (deceased)
15. Birthplace Russia

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 24 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 180

1037

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 1944 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1944 to 6/15 1944, and that I last saw him alive on 6/15 1944.

Immediate cause of death: Pneumonary TBC — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address BCH Date signed 6/17

G 18419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18419 / 122a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Butler

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-7956

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2-1877

8. AGE: Years	Months	Days	If less than one day
67	3	19	hr. min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alexander Butler
13. Birthplace md

MOTHER
14. Maiden Name Rebecca Brown
15. Birthplace md

16 (a) Informant James A. Butler
(b) Address St Timeds md

17 (a) Buried (b) Date thereof 6-24-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Calvert Co

18 (a) Funeral director Pinkney & Lowell
(b) Address Prince Frederick Md

19 JUN 24 1944 (Date rec'd by Registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1944, at 5.30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intestinal Obstruction

Due to Ventral Hernia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B McNally M.D.
Medical Examiner.

Date signed 6/22/44

VS 151

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Every item of information should be carefully supplied.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18420

BALTIMORE CITY HEALTH DEPARTMENT X G 18420 Registered No.

CERTIFICATE OF DEATH 467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wallens + Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 52 Holmehurst Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Annie Lowe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Late Joseph E Lowe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-1869

8. AGE: Years 74 Months 10 Days 17 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name John Lehenman
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Broseker
15. Birthplace Germany

16 (a) Informant Mr. Jesse Lowe
(b) Address 52 Holmehurst ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Geo. L. Beyerdo
(b) Address 1512 Hollins St

19 (a) JUN 24 1944 (b) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21/1944 at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14/1944 to 6/21/1944 and that I last saw h[illegible] alive on 6/21/1944.

Immediate cause of death Carcinoma of Recto-sigmoid — Duration 7 days

Due to —

Due to —

Other Conditions Terminal Pulmonary Embolism (Include pregnancy within 3 months of death)

Date of operation 6/19/44

Major findings of operation: Carcinoma Recto-sigmoid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wm. T. Muse M. D.
Address St. Agnes' Hosp. Date signed 6/21/44

18421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 18421 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Callow Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mollie S. Patz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband ~~or wife~~ Nathan Patz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1878

8. AGE: Years 65 Months 11 Days 3 If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Mrs. H. J. Patz,

(b) Address 3903 Fordham Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto. Hebrew

Location Balto. Md.

18 (a) Funeral director Levin Sonneborn & Son

(b) Address 1900 Eutaw Place

19 JUN 24 1944 (b) Hamilton & Hillsboro, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-23 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1944, to 6-23 1944, and that I last saw h~~er~~ alive on 6-23 1944.

	Duration
Immediate cause of death Myocardial failure	
Due to Hypertensive C.V. Dis.	
Due to	
Other Conditions Diabetes Mell: Cirrhosis, cardiac? (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy 6-23-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. S. Davis M.D.

Address Sinai Hosp. Date signed 6-25-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 18422

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore -14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Glendale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Roth

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/1857

8. AGE: Years	Months	Days	If less than one day
87	3	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Roth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary —
15. Birthplace Baltimore

16 (a) Informant George Roth
(b) Address 3201 Glendale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave.

18 (a) Funeral director M. W. L. Doppler & Sons
(b) Address 2110 Belair Rd.

JUN 24 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1944, at 5-55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1944, to 6/22 1944, and that I last saw him alive on 6/22 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Arterio-sclerotic C-V disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. N. Crosby M.D.
Address Mercy Hosp. Date signed 6/22

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 18423 G 18423

CERTIFICATE OF DEATH 1130

Registered No.

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 509 Bruguty St., Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if not foreign birth? yrs. mos. ds.

2. FULL NAME Camilla Dorsey 22-2 If U. S. Veteran specify WAR
(a) Residence: No. 509 Burguty St., 22 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	col	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph Dorsey

6. DATE OF BIRTH (month, day, year) 10/7 1912

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	8	19	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 6/1/44 11. Total time (years) spent in this occupation 5-

12. BIRTHPLACE (city or town) (State or country) md.

FATHER
13. NAME Nathan Bailey
14. BIRTHPLACE (city or town) (State or country) md.

MOTHER
15. MAIDEN NAME Mary E Nicholas
16. BIRTHPLACE (city or town) (State or country) md.

17. INFORMANT Otis Bailey
(Address) 647 Mulberry St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Date 6-24 1944

19. UNDERTAKER Mrs. Katie R. Williams
(Address) 522 N. Schroeder St.

20. FILED JUN 24 1944 19 Registrar.
Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 21 1944

22. I HEREBY CERTIFY, That I attended deceased from 6/14/44 19 to 6/21/44 19
I last saw her alive on 6/20/44 19 Death is said to have occurred on the date stated above, at 7 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
acute myocarditis Due to	
Other contributory causes of importance: Toxic Anemia	6 Mos

Was an operation performed? no Date of —
For what disease or injury? —
Name of operation —
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? — Date of injury — 19
Where did injury occur? —
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place at home
Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? no If so, specify
(Signed) Thomas Bowley M. D.
(Address) 5194 N Charles

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

18424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G 18424 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1573 Cole St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1573 Cole St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie G. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed or divorced. married

6 (b) Name of husband or wife Edw J. Davis

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 1- 1914

8. AGE: Years 79 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation HW

11. Industry or business

FATHER 12. Name Thomas Geary

13. Birthplace Balto Md

MOTHER 14. Maiden Name

15. Birthplace Balto Md

16 (a) Informant Edw J. Davis

(b) Address 1573 Cole St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk Cem City

Location

18 (a) Funeral director Lott & Brown Walter

(b) Address Pratt & Stricker Sts

19 (a) JUN 24 1944 (Date of Registration) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22 1944 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to June 1944, and that I last saw h[illegible] alive on 6-20 1944.

Immediate cause of death Hemorrhage — Duration

Due to Carcinoma of cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Karbash

Address Univers. Hospital Date signed 6-22-44

C 18225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 18225 / 920 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4805 Norwood Ave.
(c) Hospital or institution:

28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEONARD THOMAS CATLING

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Ruth Shaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1866

8. AGE: Years 78 | Months 0 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business National Biscuit Co.

FATHER
12. Name Thomas W. Catling
13. Birthplace England

MOTHER
14. Maiden Name Clara Lucus
15. Birthplace England

16 (a) Informant Mrs. Ruth S. Catling
(b) Address 4805 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ... (b) ... (Date rec'd by registrar) ... (Registrar)

JUN 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1944, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1944, to June 23, 1944, and that I last saw h alive on June 22, 1944.

Immediate cause of death	Duration
Cerebral apoplexy	4 days
Due to Arterio-sclerosis	?
Due to Chronic Endo-carditis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice E. Abrams, M. D.
Address 3300 W. North Ave. Date signed 6/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C 18426

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Woodstock Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas S. Boughter (Thomas Street Boughter)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1891

8. AGE: Years 52 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Pierce-Hebner Wiskey Whole- salers

FATHER
12. Name: Gobert Boughter
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Anna E. Boughter
(b) Address: 3410 Woodstock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery or crematory: MORELAND MEM. CEM.
Location: TAYLOR AVE.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUN 24 1944 Registrar
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22-1944, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions: Arteriosclerosis, Hypertension
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Mendelis M.D.
Medical Examiner.
Date signed 6-22-44

G 18227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 18227 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK E. DAVIS, Sr.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dora E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 12, 1873
8. AGE: Years 71 | Months 4 | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Yard Foreman
11. Industry or business Swindell Bros.

FATHER
12. Name William E. Davis
13. Birthplace Ellicott City, Md

MOTHER
14. Maiden Name Emily J. Haddaway
15. Birthplace Kent Co., Md.

16 (a) Informant Mrs. Dora E. Davis
(b) Address 726 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Received by Local Registrar (month) (day) (year) (b) Registrar
JUN 24 1944
VS 150
Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 22, 1944, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 19 43 to June 22 1944, and that I last saw h alive on June 21 1944.

Immediate cause of death: Cerebral Embolism
Antecedent causes: Chronic Interstitial Nephritis
Due to
Due to
Other Conditions Hypertensive Coronary
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Hours / Days / Months / Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Dorsey M. D.
Address 617 Medical Arts Bldg. Date signed June 23/44

G 18428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

G 18428 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 22 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Christopher Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Graham Haase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 15 42

8. AGE: Years	Months	Days	If less than one day
1	22 10	8	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George F Haase
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret E Graham
15. Birthplace Maryland

16 (a) Informant Geo F Haase
(b) Address 2712 Christopher ave

17 (a) Burial (b) Date thereof June 26.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-6 Aliceanna St

19 (a) JUN 24 1944 (b) Registrar Baltimore, Md.
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944 at 11 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1944 to June 23 1944 and that I last saw him alive on June 23 1944 11 40 AM

Immediate cause of death: Acute laryngo-trachea bronchitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Guyther M. D.
Address Mercy Hosp Date signed 6/25/44

G 18429

BALTIMORE CITY HEALTH DEPARTMENT

JL - 88615

CERTIFICATE OF DEATH

13B

G 18429

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 741 S. Luzerne St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Kreger

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1902

8. AGE: Years 42 | Months 0 | Days 9 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business Self.

FATHER

12. Name: Frank K. Kreger

13. Birthplace: Poland

MOTHER

14. Maiden Name: Mary ?

15. Birthplace: Poland

16 (a) Informant: B. C. H. Records

(b) Address: 4940 Eastern Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 26/44 (month) (day) (year)

(c) Cemetery or crematory: Holy Rosary

Location: Baltimore

18 (a) Funeral director: Fred W. Ozarowski

(b) Address: 1930 Eastern Ave.

19 JUN 24 1944 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-23 1944, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1944 to 6-23 1944 and that I last saw him alive on 6-22 1944.

Immediate cause of death: Pulmonary Embolism — Duration: 5 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattma M. D.

Address B. C. H. Date signed 6/24/44

M. D. R. 1202-6

C 18430 **HEALTH DEPARTMENT—CITY OF BALTIMORE** C 18430

CERTIFICATE OF DEATH ✓ 107

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Mahon St., Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Eveline Newman

(a) Residence: No. 1308 Mahon St., 16-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

6a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Newman

6. DATE OF BIRTH (month, day, year) 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Clinton Newman

(Address) 1308 Mahon St

18. (BURIAL), CREMATION, OR REMOVAL

Place Mt Auburn Date 6-25-44 19

19. UNDERTAKER George H. Kelson

(Address) 1334 Eastern Ave

20. JUN 24 1944 Thurston Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 22, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 14, 1944 to June 22 1944

I last saw h alive on June 22, 1944 Death is said to have occurred on the date stated above, at 9:15 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	6-14-44
Other contributory causes of importance: Acute Cardiac Failure	6-21-44

Name of operation Date of

What test confirmed diagnosis? Physical Signs & Symptoms Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) John E. J. Campbell M. D.

(Address) 1308 Mahon St

R. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 18431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

C 18431 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME margaret King

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	married

6 (b) Name of husband or wife Luther C. King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1918

8. AGE: Years	Months	Days	If less than one day
25	6	28	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Filbert Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Irene Thompson
15. Birthplace Va

16 (a) Informant Luther King
(b) Address 2106 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-44 (month) (day) (year)
(c) Cemetery or crematory Northumberland Co Va
Location Va

18 (a) Funeral director George H Nelson
(b) Address 1313 Pennsylvania Ave

19 (a) JUN 24 1944 (Registered by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 4 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944, to June 23 1944 and that I last saw h[illegible] alive on June 23 1944

Immediate cause of death Ca of Cervix — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 803 N [illegible] Date signed

VS 3

~~18432~~ G 18432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G 18432

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Broadway (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Lawrence Miller

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: ANGLINE MILLER
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) FEB. 2-1859
8. AGE: Years 85 | Months 3 4 | Days 29 2 0 | If less than one day ..... hr. ..... min.
9. Birthplace: ITALY (Town, county, and state)
10. Usual Occupation: PHOTOGRAPHER
11. Industry or business: FOR SELF

FATHER
12. Name: UNKNOWN
13. Birthplace: ITALY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: ITALY

16 (a) Informant: CECELIA FRERRIS (DAUGHTER)
(b) Address: 1710 LANG PLACE N. EAST W.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 27/44 (month) (day) (year)
(c) Cemetery or crematory PLEASENT HILL CEM.
Location ATLANTIC CITY, N.J.

18 (a) Funeral director: Lillyand Zeiler INC.
(b) Address: 403 S. WOLFE ST. AT

19 (c) JUN 24 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 7 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Multiple Skull Fractures

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 22 1944 11 15 A.M.
(b) Where did injury occur? 518 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? yes
(d) Means of injury Blunt force

23. Signature Robert Lee Fraser M.D. Medical Examiner.
Date signed June 23, 1944

18433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G 18433 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5307 Remmel Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5307 Remmel ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura A. Atkinson 32136

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1912

8. AGE: Years	Months	Days	If less than one day
32	1	6 5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William R. Ward
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna J. Gluth
15. Birthplace Baltimore, Md.

16 (a) Informant William Atkinson
(b) Address 5307 Remmel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) JUN 24 1944 (b) Huntington Williams M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1944, to June 21 1944, and that I last saw h. alive on June 21 1944.

Immediate cause of death	Duration
Puerperal Eclampsia	1 hr
Due to Premature labor	
dead child 7 mos gestation	1 wk
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Brennan and Bond M. D.
Address 2200 Jarvis Blvd Date signed 6/24/44

18434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 181

G 18434
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 5/2/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 5/2/44

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 South Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GUISEPPI MARRO

3 (b) If veteran, name war	3 (c) Social Security Account No.
- NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 15, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	6	hr. min.

9. Birthplace ? Italy (Town, county, and state)
10. Usual Occupation Oiler - Merchant Marine
11. Industry or business "

FATHER
12. Name Nick Marro
13. Birthplace ? Italy

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ? Italy

16 (a) Informant Records, U. S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 24/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly - Zeiler Co.
(b) Address 403 S. COLLE ST.

19 JUN 24 1944 (Date Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

For S. H. Mc-Nally, Dy Hy. Mallonee M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 21, 1944, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2, 1944, to June 21, 1944 and that I last saw him alive on June 21, 1944

Immediate cause of death	Duration
1. External second & third degree burns of both extremities, the perineum, scrotum and penis; 2. Marked toxic myocarditis, hepatitis and nephritis.	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/3, 5/6, 5/11, 5/15- Debridement & cleansing of burns;
Major findings of operation: 5/28/44-Skin graft, rt. & left legs
Findings of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Yes Y-90 P.
(b) Date of occurrence April 17, 1944 at 2:30 M
(c) Where did injury occur? Off Azore Islands-Convoy (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At sea (Specify type of place) While at work? Yes
(e) Means of injury Burning paint accidently spilled on him by fellow-worker.
23. Signature

Address U.S. Marine Hosp. Baltimore, Md. Date signed 6/22/44 M. D.

DMS-52762

18435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18435

Registered No. 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 Bonnie Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Bonnie Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Wing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	W.

6 (b) Name of husband or wife Booker Wing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1918

8. AGE: Years	Months	Days	If less than one day
25	6	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Griffin Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Nancy Corbin
15. Birthplace Va.

16 (a) Informant Susetta Haskins
(b) Address 310 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 JUN 24 1944 (Date rec'd by registrar) (b) Huntington Wilson Reg. M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 12 1 P.M. A

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frates M.D. Medical Examiner.
Date signed June 21, 1944

G 18436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

946 SECT 5 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 183 S. Hosmith St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Anderson

3 (b) If veteran, name war

3 (c). Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Angie nee Chappel

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1876

8. AGE: Years	Months	Days	If less than one day
58	9	27	hr. 18 min. 5

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business National Casket Co.

FATHER
12. Name — Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Mrs. Angie Anderson
(b) Address 183 S. Hossith St

17 (a) Removal (b) Date thereof 6/26/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Harrisonburg Virginia

18 (a) Funeral director Harry H. Wilkes
(b) Address 401 E. Lanvale St.

19 (a) (b) Thursday

JUN 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23 1944, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dwight O. McNally
Medical Investigator
Address Date signed 6/24/44

G 18432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 18432 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S Stoll Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Segety

3 (b) If veteran, name war —

3 (c) Social Security Account No. 232-12-5916

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 22 - 1915

8. AGE: Years 28 | Months 8 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Gary W. Va. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Shipyards

FATHER — 12. Name George Segety

13. Birthplace Hungary

MOTHER — 14. Maiden Name Kalhoko

15. Birthplace Hungary

16 (a) Informant Geo. Segety

(b) Address 1005 Stoll Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Welch W. Va.

18 (a) Funeral director MARTIN FAHEY & SONS

(b) Address 1827 W. North Ave.

19 (a) JUN 28 1944 (Date received by Registrar) (b) Washington Hillsboro, W. Va.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-23- 1944, at 6 23 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
Fractured Skull

Due to

Other Conditions Fractured Pelvis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-22-44 at 25/6 3 P M.
(b) Where did injury occur? Bethlehem Fairfield Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fall from 35' ladder

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 6-24-44

G 18438 ✓ G 18438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution: Monument St & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12
(e) Length of stay in Baltimore (yrs., mos., or days): 9 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 214 E 24th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME Harry Sigel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation:

11. Industry or business: Shoe Repairing

FATHER
12. Name: Abraham Sigel
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rachael ?
15. Birthplace: Russia

16 (a) Informant: Marcus Weitz
(b) Address: 2931 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 JUN 25 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/23 1944, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1944 to 6/23 1944 and that I last saw him alive on 6/23 1944.

Immediate cause of death: Myocardial insufficiency — Duration:

Due to: Myocardial infarction

Due to: Arteriosclerotic L. dis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Leonard Abrams M.D.
Address: Sinai Hospital Date signed: 6/24/44

C 18439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Elizabeth Murphy

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife James N. Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1866

8. AGE: Years	Months	Days	If less than one day
78	0	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John McKeever
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Hughes
15. Birthplace Ireland

16 (a) Informant Mr. James J. Murphy
(b) Address 2304 Forest Park Ave.,

17 (a) Burial (b) Date thereof June 26, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) JUN 26 1944 (b) [illegible]
(Registrar's signature) Registrar

VS 150

MEDICAL CERTIFICATION 2.00

20. DATE OF DEATH June 23, 1944, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1/42 19[illegible] to June 23 1944 and that I last saw h[illegible] alive on June 2 1944.

Immediate cause of death	Duration
Myocarditis	1 mo.
Due to advanced arterio-sclerosis	?
Due to	
Other Conditions Diabetes	about 4 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, ~~industrial place~~, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter F. Hibbitt M. D.
Address 2220 Harrison Blvd Date signed June 23/44

G 18440 ✓ G 18440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 137a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied as far as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Nusenow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation Store Keeper
11. Industry or business

FATHER
12. Name Obrege
13. Birthplace Russia

MOTHER
14. Maiden Name Fayne
15. Birthplace Russia

16 (a) Informant Ida Nusenow
(b) Address 2809 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-44 (month) (day) (year)
(c) Cemetery or crematory Wash. Rel.
Location Pimlico

18 (a) Funeral director Jacob Lewis Sons
(b) Address 1439 E. Pratt St

19 (a) JUN 23 1944 (Date rec'd by registrar) (b) Huntington-Williams Mort. Co.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 10:40 PM

21. I certify that death occurred on the date above stated, that I attended deceased from May 17 1944 to June 23 1944 and that I last saw him alive on June 23 1944

Immediate cause of death	Duration
Embolism - Cerebral	Hours
Due to Transurethral Prostatectomy	40 days
Due to Transurethral	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 14, 1944
Major findings of operation Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry Nusenow M.D.
Address 1924 W North Ave Date signed 6/23/44 D.

G 18441 ✓ G 18441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Farmville Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name not NONE
13. Birthplace " "

MOTHER
14. Maiden Name Grace Banks maden
15. Birthplace Farmville Va.

16 (a) Informant Mrs Lillian Banks Wife
(b) Address 333 Forest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26th 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Ebury O Wilson
(b) Address 1000 Brantley Ave, Baltimore, Md.

19 (a) JUN 24 1944 (Date rec'd by registrar) (b) Twenty-four hours after death Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 6.40 P M.

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage, spontaneous

Due to

Other Conditions
Name not none
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraser M.D. Medical Examiner.
Date signed June 23, 1944

G 18442 ✓ G 18442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

550 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 302 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Goode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Goode

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1886

8. AGE: Years 57 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Lenard Johns.
13. Birthplace Md.

MOTHER — 14. Maiden Name Francey Lee
15. Birthplace Md

16 (a) Informant Frances Sewell
(b) Address 302 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 B Hanover Ave

(c) (Date received by registrar) JUN 25 1944 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944 to June 21 1944 and that I last saw h[illegible] alive on June 21 1944.

Immediate cause of death: Carcinomatosis — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Rackley Jr.
Address 426 N. Lyndhurst Date signed 6/24/44

G 18443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

✓ G 18443 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 E. Clement St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Carrie) Carey Allena (allum)

3 (b) If veteran, name war —

3 (c) Social Security account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13-1939

8. AGE: Years 5 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James J. Allum
13. Birthplace Ireland

MOTHER
14. Maiden Name Carrie Kirby
15. Birthplace Baltimore Md.

16 (a) Informant James J. Allum
(b) Address 140 E Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-1944 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Flannigan
(b) Address 1426 Light St.

19 (a) JUN 25 1944 (Date rec'd by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 8:05 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to
1st Burns 1st & 2nd degree
Burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 22, 1944 24/3 M.
(b) Where did injury occur? 140 E. Clement St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Clothes caught from match

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 23, 1944

G 18444 ✓ G 18446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 Belgian Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 Belgian Ave (If rural give location)
(e) Citizen of foreign country? Belgium (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Leo Burlage

3 (b) If veteran, name war: World War I | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14-1891

8. AGE: Years 52 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name John J. Burlage
15. Birthplace Germany

MOTHER: 14. Maiden Name Katherine Kohlemann
15. Birthplace Ireland

16 (a) Informant Peterson
(b) Address 831 Belgian Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John A. Moran
(b) Address 3000 Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

Number

JUN 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1944 to June 20 1944, and that I last saw him alive on June 19 1944

	Duration
Immediate cause of death: Hemorrhage of Lungs	2 days
Due to: Carcinoma RS Lung	6 mos.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 6/23/44

18445 H53689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 55C G 18445

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County
(c) City or town Shady Grove
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester W. Mentzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-18-02

8. AGE: Years 42 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Penn-
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Grant

FATHER 12. Name Lester W. Mentzer

13. Birthplace Md. -

MOTHER 14. Maiden Name Alice Gordon -

15. Birthplace Penn.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/25/44 (month) (day) (year)

(c) Cemetery or crematory

Location Greencastle, Pa.

18 (a) Funeral director C. Eugene Minnich

(b) Address Greencastle, Pa.

JUN 26 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944, at 1.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to June 25 1944 and that I last saw h.i.M alive on June 25 1944.

Immediate cause of death: Cardiac and respiratory failure — Duration:

Due to: Extreme cachexia

Due to: Carcinoma of Thyroid with carcinomatosis — 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinomatous

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature: Georg Bunch M. D.

Address Johns Hopkins Date signed 6-25-44

G 1846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H Registered No. G 1846

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Krugs

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife: Sallie H. Krugs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace: Waynesboro Pa. (Town, county, and state)
10. Usual Occupation: Plasterer
11. Industry or business: Building

FATHER
12. Name: Krugs
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: John E. Coale
(b) Address: 1307 N. Calvert St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st

19. JUN 26 1944 (Date received by Registrar) Registrar of Vital Statistics, Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~suicide~~ ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 22nd 1944 10:30 P.M.
(b) Where did injury occur? 408 W. Mulberry St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Turned on stove burners

23. Signature: Robert Lee Graham M.D. Medical Examiner.
Date signed June 23, 1944

Dup 18447

BALTIMORE CITY HEALTH DEPARTMENT X V G 18442
CERTIFICATE OF DEATH 170C Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #4 Box 47 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Ellsworth Millard

3 (b) If veteran, name war: World war I
3 (c) Social Security Account No. 223-20-6684

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1886

8. AGE: Years	Months	Days	If less than one day
58	0	5	hr. min.

9. Birthplace Northumberland, Pa. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business (unemployed)

FATHER
12. Name Reuben O. Millard
13. Birthplace Bloomsburg Pa.

MOTHER
14. Maiden Name Mary Fisher
15. Birthplace Millville, Pa.

16 (a) Informant Charles W. Millard
(b) Address Norfolk, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-44 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (c) JUN 26 1944 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1944, at 6.15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull, Crushed legs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 23 1944 Baltimore M.
(b) Where did injury occur? Philadelphia Rd + Quarantine
(c) Did injury occur at home, on farm, industrial place, in public place? Public Road While at work? No
(d) Means of injury Laceration + crush by auto

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 23, 1944

G 18445 Hipchen ✓ G 18445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Burnett Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Hipchen

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1896

8. AGE: Years	Months	Days	If less than one day
47	8	3	hr. min.

9. Birthplace INDIANNA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER	12. Name GEORGE HIPCHEN
	13. Birthplace GERMANY
MOTHER	14. Maiden Name MARGT GERSTNER
	15. Birthplace GERMANY

16 (a) Informant MARGARET HIPCHEN
(b) Address 110 BURNETT ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A A Co

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 (a) Date received JUN 26 1944 (b) Thursday Williams M.R. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24- 1944, at 5:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mullen M.D. (Medical Examiner.)
Date signed 6-24-44

G 18445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57L

Registered No. G 18445

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 E Chase (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Ann Mc Arthur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-38

8. AGE: Years	Months	Days	If less than one day
5	9	27	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Luther Mc Arthur
13. Birthplace N.C.

MOTHER
14. Maiden Name Lillian Burgess
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cemetery
Location Gd. Cordu

18 (a) Funeral director Lottie Grosa
(b) Address 1408 Ashland ave

JUN 26 1944 (b) Huntingtown Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1944, at 1245 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1944, to June 24 1944, and that I last saw he R alive on June 24 1944.

Immediate cause of death Respiratory Failure — Duration: 5 days

Due to Increased Intercranial pressure

Due to Tumor of brain?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: large ventricles, no cerebellar tumor found

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Jay Dorsey M.D.
Address Johns Hopkins Hospital Date signed 6-24-44

G 18450 ✓ G 18450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1446 N Gay St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Annie M Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Henry J Zimmerman

6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr.) Oct 23-1866

8. AGE: Years	Months	Days	If less than one day
77	8	0	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Henry J Zimmerman
(b) Address 1416 N Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Merchell E Humphreys
(b) Address 1501 N. Broadway.

19 (a) JUN 26 1944 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 - 19XX, at 11½ P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jun 15 1944 to June 24 1944, and that I last saw her alive on June 23 1944.

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to:

Due to: Macrocytic Anemia - Etiology 6 mos.

Other Conditions: undetermined

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Karl Grossman M. D.
Address 1212 N. Patterson Pk Ave Date signed 6 [illegible] 44

G 18451 ✓ G 18451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1182 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Zora Hugh Hampton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Richard O. Hampton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1877

8. AGE: Years	Months	Days	If less than one day
67	0	0	hr. min.

9. Birthplace Tappahanock, Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 7 57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1944 to June 23 1944 and that I last saw her alive on June 23 1944

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Terminal Bronchopneumonia	3 da
Due to Pyloric obstruction due to Chronic inflamatory tissue	
Other Conditions due to Chronic Cholecystitis	

(Include pregnancy within 3 months of death)

Date of operation June 20 1944
Major findings of operation: Pyloric obstruction inflamatory tissue and intestinal adhesions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James H. McCosh Jr. M. D.
Address Womens Hospital Date signed 6-23-44

G 18452 Covell G 18452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mr.) Nelson S. Covell

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mabel B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1893

8. AGE: Years	Months	Days	If less than one day
51	4	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Chiropractor
11. Industry or business

FATHER
12. Name Wm. B. Covell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Georgia Covell Ward
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mabel B. Covell
(b) Address 1949 Edmondson Ave.

17 (a) Burial (b) Date thereof 6/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 26 1944 Washington Williams, M.D.
(Date received by Registrar) (Signature and degree of attendant)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 19 44 at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 19 44 to 6/25 19 44, and that I last saw h-e alive on 6/25 19 44

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Clifton Cushing M.D.
Address St. Agnes Hosp Date signed 6/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

Registered No. C 10253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Central Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Central Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ferguson S. Hynes Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1916

8. AGE: Years 28 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace King William County Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ferguson S. Hynes Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Burrell
15. Birthplace Va.

16 (a) Informant Ada Boulden
(b) Address 926 Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. G. Ellis & Son
(b) Address 1129 N. Carline St.

JUN 26 1944 (b) Huntington Williams, M.D.
Date rec'd (month) (day) (year)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 11:19 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 42 to 6/22 1944, and that I last saw him alive on 6/23 1944.

Immediate cause of death Hypostatic Pneumonia — Duration 4 Day
Due to Potts Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1942
Major findings of operation: Potts Disease - Tuberculosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Alexander
Address 522 N. Bond Date signed 6/26/44

G 18454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 f

G 18454 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Chesterfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Chesterfield ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN CASCIERO

3 (b) If veteran, name war 1st W. W. | 3 (c) Social Security Account No. 213-09-5536

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ wife MANNIE CASCIERO

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 30-1895

8. AGE: Years 49 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace CAPRACOTTA ITALY
(Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

MOTHER / FATHER

12. Name DOMENICO CASCIERO

13. Birthplace ITALY

14. Maiden Name NUNZIA DICESARE

15. Birthplace ITALY

16 (a) Informant MANNIE CASCIERO (Wife)

(b) Address 3012 CHESTERFIELD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 27-44 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR RD.

18 (a) Funeral director Frank Della Rocca

(b) Address 524 W. Morley St.

19 (c) JUN 26 1944 Registered by registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1944, at 10 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943, to June 24 1944, and that I last saw h[illegible] alive on June 24 1944

Immediate cause of death Adeno Carcinoma of Liver & metastasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 18 - 43

Major findings of operation Adeno Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Charles A Anderson M. D.

Address 3001 Clarmont Ave Date signed June 24-44

G 18455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G 18455 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6901 Reisterstown Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6901 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country -

3 (a) FULL NAME William Henry Matthai

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-20-6601

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Alice J. Matthai

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1856

8. AGE: Years 87 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John C Matthai
13. Birthplace Germany

MOTHER
14. Maiden Name Teresa Jackins
15. Birthplace Alsace Lorraine

16 (a) Informant Mr. W. Howard Matthai (Son)
(b) Address Garrison Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Mayer Co.
(b) Address 108 W North Ave.

19 (a) [illegible] JUN 26 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944 at 9 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1936 to June 23 1944 and that I last saw h[illegible] alive on June 23 1944.

Immediate cause of death: Coronary Thrombosis.

Duration: 12 hrs.

Due to: Arteriosclerosis.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Galen R Williams

Address Pikesville Md Date signed 6/24/44 M. D.

G 18456 ✓ G 18456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. (male)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 S 41st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S 41st St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cennie E. Hoover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1869

8. AGE: Years 74 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Joseph Evans

13. Birthplace Pa

MOTHER 14. Maiden Name Lucy Knabb

15. Birthplace Pa

16. (a) Informant R. Hoover

(b) Address 518 S 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1944 (month) (day) (year)

(c) Cemetery or crematory Forest Lawn

Location Towson Md

18 (a) Funeral director John A. Pearson

(b) Address 3000 Sheffield Ave Funeral Home Walbrook, Md

19 (a) (Date received by Registrar) JUN 26 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1944, at 9 Pc M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1940 to June 1944. and that I last saw h alive on June 23 1944.

	Duration
Immediate cause of death: Arteriosclerosis	1988
Central Nephritis	1940
Due to Chr. Ad Nephritis	1940
Due to	
Other Conditions Influenza	1944

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Bratz M. D.

Address 501 S Linden Ave Date signed June 25 44

G 18452 X G 18452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Rebecca Hoke

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col.	widowed

6 (b) Name of husband ~~of wife~~ Dunbar Hoke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1879

8. AGE: Years	Months	Days	If less than one day
65	1	14	hr. min.

9. Birthplace Perryman, Harford
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Martha
15. Birthplace Perryman, Md.

16 (a) Informant Hoke Bishop
(b) Address Aberdeen, Md.

17 (a) Burial (b) Date thereof June 29, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union M. E.
Location Aberdeen Md

18 (a) Funeral director Henry Torring Home
(b) Address Aberdeen Md

JUN 26 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to June 25 1944, and that I last saw h alive on June 25 1944

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Carcinomatosis	months
Due to Carcinoma of Sigmoid	months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/20/44
Major findings of operation: Obstruction Carcinoma of Sigmoid
If autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Rodman Higgins
Address 743 Madison Ave Date signed 6/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G 18458 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 W RANDALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County KENT.
(c) City or town CHESTERTOWN.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 355 High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE WILTBANK.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: WRIGHT WILTBANK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1884

8. AGE: Years 59 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name FRED. WERSTEN
13. Birthplace BALTO MD

MOTHER
14. Maiden Name LOUISE SMITH
15. Birthplace BALTO MD

16 (a) Informant MRS MARY WERSTEN
(b) Address 108 W. RANDALL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-27-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location BALTO MD

18 (a) Funeral director Bernard C. Hoke
(b) Address 121 E WEST ST

19. (a) JUN 26 1944 (Date rec'd by registrar) Hamilton F. Williams, M.D. Registrar

VS 150

JUN 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 24 1944 at 1230 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 24 1944 and that I last saw h[illegible] alive on June 24 1944

Immediate cause of death Carcinoma - Ovary.

	Duration
Due to	
Due to	
Other Conditions Myocardial Insufficiency (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation: —	
of autopsy: —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian A. Schwent M.D.
Address 1337 E. Chase St Date signed 6/26/44

G 18455

BALTIMORE CITY HEALTH DEPARTMENT

AB-84343

CERTIFICATE OF DEATH

Registered No. G 18455

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos- 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Boggs -or- Ernit Boggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Leona
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/1907

8. AGE: Years	Months	Days	If less than one day
36	9	27	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Oswell Boggs
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Walker
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address

17 (a) Burial (b) Date thereof June 27 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakmont
Location Accomac Co Va

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 332 N Schroeder St.

19 JUN 26 1946 (b) Hughesville, Md.
(Filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22- 1946, at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1943, to 6-22 1946 and that I last saw h[illegible] alive on 6-22 1946.

Immediate cause of death Pulmonary tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Paul Mattone
Address B.C.H. Date signed 6/25/46

18460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√830

Registered No. G 18460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1733 E Pratt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina (Smayle) Smalinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Kazimierz Smalinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1883

8. AGE: Years	Months	Days	If less than one day
61	1	10	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Danski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Mrs. Kazimierz Smalinski
(b) Address 1733 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. DeWees
(b) Address 401 S. Chester Street

JUN 26 1944 (b) Huntingdon Williamsport, Md.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION 850

20. DATE OF DEATH June 25 1944, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1944, to June 25 1944; that I last saw h[illegible] alive on June 25 1944

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 6/13/44

Due to GENERALIZED ARTERIO-SCLEROSIS — 727

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Duenga M. D.
Address 209 E. Chester St Date signed 6/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~18461~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G 18461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2623 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. W2623 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie P.Beck,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John P.Beck,

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 15.1880

8. AGE: Years 64 | Months 3 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Smithsburg Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name David H.Phetteplace
13. Birthplace Providence R.I.

MOTHER
14. Maiden Name Elizabeth Masters,
15. Birthplace Germany

16 (a) Informant John P.Beck,
(b) Address 2623 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28 1944 (month) (day) (year)
(c) Cemetery or crematory Smithsburg
Location Smithsburg Md.

18 (a) Funeral director Robert S.Little.
(b) Address 2700 Edmondson Ave.

19 (a) JUN 26 1944 (b) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 24 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16-41 19 , to 6-24 19 44 and that I last saw h alive on 6-24-44

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Hypostatic pneumonia — Duration 1 week

Due to Cerebral accident

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Harry S. Lumbel M. D.

Address 2702 Edmondson Date signed 6-26-44

18462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18462

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 W.Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 74 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 5
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 W.Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A.Celeste Jenkins,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph J.Jenkins,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.7.1857

8. AGE: Years	Months	Days	If less than one day
86	6	18	hr. min.

9. Birthplace Baltimore Co.Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Benedict Harris,
13. Birthplace Del[illegible]

MOTHER
14. Maiden Name Julia Merideth.
15. Birthplace Kent Co. Md.

16. (a) Informant Miss Ella C.Jenkins,
(b) Address 2522 W.Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27.1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md.

18 (a) Funeral director George W.Little,
(b) Address 2700 Edmondson Ave.

19 JUN 26 1944 (b) [illegible] Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 25 1944 at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15- 1932, to 6-25- 1944, and that I last saw h[illegible] alive on 6-20- 1944

Immediate cause of death	Duration
Acute Pneumonia	7 da.
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Piland, M. D.
Address 2532 Edmondson Ave Date signed 6-25-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly, and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193E

Registered No. 2698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 Lafayette Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-1896

8. AGE: Years 48 | Months 2 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace South Hill Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business own home

FATHER
12. Name Wilson Harris
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Mrs Mildred Smith
(b) Address 1234 Lafayette ave

17 (a) ... (b) Date thereof 6/26/44
(burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory La Grossa 6-28-44
Location

18 (a) Funeral director George T. G. Gibson Sr.
(b) Address 1735 Druid Hill ave

19 JUN 26 1944 (Registered by Registrar) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14-1944, to 6-25-1944, and that I last saw her alive on 6-24-1944.

Immediate cause of death ... Duration
Myocarditis ... unknown
Due to unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St. Date signed 6-25-44

G 18464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18464

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #605 Grantley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. #605 Grantley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna L Scully

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Thomas P. Scully

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1874

8. AGE: Years 70 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER: 12. Name Unknown
13. Birthplace Germany

MOTHER: 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Anna Knight
(b) Address #605 Grantley St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/28/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) (Date received by Registrar) H. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th 1944 at 2:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1944 to 6/25 1944 and that I last saw h[illegible] alive on 6/25 1944

Immediate cause of death: Acute Pulmonary Edema — Duration 1 day

Due to: Hypertensive Cardio Vascular Disease — Duration 5+ yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Poole
Address 3629 Edmondson Ave Date signed 6/26/44 M.D.

C 18265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944 C 18265 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Tramore Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil A. Newcomb

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4299

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Carrie E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29 1895

8. AGE: Years	Months	Days	If less than one day
48	5	27	hr. min.

9. Birthplace Elmont, Va.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Bartlett Hayward

FATHER 12. Name John Daniel Newcomb

13. Birthplace Va.

MOTHER 14. Maiden Name Lottie E. Amos

15. Birthplace Va.

16 (a) Informant Mrs. Cecil A. Newcomb

(b) Address 5505 Tramore Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location

18 (a) Funeral director Leonard Hartman

(b) Address 5325 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS JUN 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —

(d) Means of injury —

23. Signature Chester F. Sulinski M.D.
Medical Examiner.

Date signed 6/27/44

C 18266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

C 18266

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Northern Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mildred H. Stover

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-7919

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Frank Stover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1902

8. AGE: Years	Months	Days	If less than one day
42	4	18	hr. min.

9. Birthplace Newport News, Virginia (Town, county, and state)
10. Usual Occupation Office Supervisor
11. Industry or business Edgewood Arsenal

FATHER
12. Name Leo O. Goetzinger
13. Birthplace Wash, D.C.

MOTHER
14. Maiden Name Emma K. Kauffman
15. Birthplace Luray, Va.

16 (a) Informant Mr. Frank S. Stover
(b) Address 2811 Northern Parkway

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-28-44 (month) (day) (year)
(c) Cemetery or crematory Beahm's Chapel
Location Luray Va.

18 (a) Funeral director Lemmon Mortuary
(b) Address 5305 Harford Rd.

19 (a) (Date received by Registrar) (b) Registrar

JUN 26 1944

VS-15b

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 1944, at 5:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1944 to 6/25 1944, and that I last saw her alive on 6/25 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Medullary Anoxia	
Due to Shock	
Other Conditions Acute Pancreatitis (Hemorrhagic)	

(Include pregnancy within 3 months of death)

Date of operation 6/27/44

Major findings of operation: Acute Hemorrhagic Pancreatitis, Cholelithiasis

of autopsy:

PHYSICIAN
Underline the name to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E Halverstrom M. D.
Address Univ. Hosp. Date signed 6-25-44

G 18467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

G 18467 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 954 Forrest St.

(c) Hospital or institution: Maryland Penitentiary 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ??

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. C. (b) County Wake

(c) City or town Nicedale 13

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John Hinton

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Hinton

6 (c) If alive, give age ?? years

7. Birth date of deceased (mo., day, yr.): May 17, 1918

8. AGE: Years 26 | Months — | Days 30 | If less than one day: hr. min.

9. Birthplace: Wake County, N. C. (Town, county and state)

10. Usual Occupation: Farm hand

11. Industry or business

MOTHER FATHER

12. Name: Willis Hinton

13. Birthplace: Wake County, N. C.

14. Maiden Name: Dicy Smith

15. Birthplace: Wake County, N. C.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 26 1944

18 (a) Funeral director JUN 26 1944

(b) Address

19 JUN 26 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944 at 12:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944 to June 16 1944, and that I last saw him alive on June 16 1944.

Immediate cause of death: Dislocation of 5th cervical vertebra — Duration

Due to: Execution by hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C T Harris M. D.

Address 954 Forrest St. Date signed 6-16-44

VS 180

1039

G 18268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18268

Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 E 32nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 E 32nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion H Liegman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Agnes L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1896

8. AGE: Years 47 | Months 48 | Days 8 | If less than one day hr. min. 19

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry G. Liegman
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Barrett
15. Birthplace Md

16 (a) Informant Agnes L Liegman
(b) Address 1811 E 32nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Jos L Morgan
(b) Address 2000 Eastern Ave

19 (a) Registrar Wm T Williams, M.D.

JUN 26 1944

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1944 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16, 1944, to June 24, 1944, and that I last saw him alive on June 23, 1944

Immediate cause of death Uremia — Duration May 16/44

Due to Chronic nephritis — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo B. Seybert M.D.
Address 2102 Harford Rd Date signed 6-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and no space left unfilled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 432

G 18465 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Forest Av
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Wm Hill Diefelder (DILLFELDER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-1775

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1889

8. AGE: Years	Months	Days	If less than one day
54	11	8	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business John Schill

FATHER
12. Name Wm. Fred Felder

13. Birthplace Germany

MOTHER
14. Maiden Name ?

15. Birthplace Germany

16 (a) Informant John Schill

(b) Address 1131 Greenmount Ave

17 (a) Burial (b) Date thereof 6/28/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Schwartz

Location Balto. Md.

18 (a) Funeral director Wm Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) JUN 27 1944 (Date received by registrar) Thomas Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26- 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....

Chronic Myocardial Degeneration

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Howard J. Thomsen M.D.
Medical Examiner.

Date signed 6-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18470 — BALTIMORE CITY HEALTH DEPARTMENT — G 18470 Registered No.

CERTIFICATE OF DEATH

13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 4
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Booker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1873

8. AGE: Years 70 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER: 12. Name Unknown
13. Birthplace

MOTHER: 14. Maiden Name Garden
15. Birthplace Va.

16 (a) Informant Maggie Wilson
(b) Address 1202 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 915 Druid Hill Ave

19 (a) JUN 27 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1944 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7/44 to 6/26/44 and that I last saw her alive on 6/25/44.

Immediate cause of death Pneumonia
(a) Phlebitis

Duration 3 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Eliason M. D.
Address 1 East Madison Date signed 6/29/44

act # G 1871 — BALTIMORE CITY HEALTH DEPARTMENT — G 1871

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8125 Old Phila. Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Dildine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Wm Dildine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30th 1907

8. AGE: Years 36 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name (Unknown) Moriety

13. Birthplace Ireland

MOTHER 14. Maiden Name Mc Kinnon

15. Birthplace "

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/27/44 (month) (day) (year)

(c) Cemetery or crematory Portland

Location Pa.

18 (a) Funeral director William Cook Inc

(b) Address 7 St. Paul St.

19 JUN 27 1944 (Date rec'd by registrar) (b) Hunt Valley Md

VS 188 for Interment, by Howard J. Moreis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Richard Wright M. D.

Address Johns Hopkins Date signed 6-28-44

The death cert. of
Catherine M. Dildine, correct-
ion made on removal
date - should be 21th
instead of 20th of June
Date of death - 23rd June.
G. 18471 Wm Cook, Insc.
Per Butler

G 10472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 10472

TO #85928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Joseph Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1906

8. AGE: Years 38 | Months -1- | Days -7- | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac (Adopted) (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha ? (Adopted) (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 27 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1944 to 6/13 1944 and that I last saw h alive on 6/13 1944.

Immediate cause of death	Duration
Pulmonary TBC	1 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Seligman M. D.
Address 18 C.H. Date signed 6/20

1042

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18475
Clinic

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30 f

G 18475 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: President Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E Jefferson st (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Baby Foster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-44

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Abraham Foster
FATHER 13. Birthplace Blackstock S.C.
MOTHER 14. Maiden Name Frances Coleman
MOTHER 15. Birthplace Blackstock S.C.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 26 1944
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) JUN 27 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11 1944, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1944 to 6-11 1944, and that I last saw him alive on 6-10 1944.

Immediate cause of death	Duration
Malnutrition	
Due to Prematurity	
Due to Congenital Lues	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Louise Jones M. D.
Address 1100 Druid Park Drive Date signed 6/13/44

1041

G 10474 ✓ G 10474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: W. B. G. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4944 Denmoor Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Baby Girl Lowe

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced. .....

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years ..... Months ..... Days ..... If less than one day: 2 hr. 54 min.

9. Birthplace W. B. G. H. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name Thomas Woodrow Lowe
13. Birthplace Balt. Md.

MOTHER 14. Maiden Name Francis Theodora Jeremick
15. Birthplace Kulpsmont, Pa.

16 (a) Informant .....
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location UNIVERSITY MEDICAL SCHOOL JUN 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 JUN 27 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944, at 7:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1944, to June 25 1944, and that I last saw her alive on June 25 1944.

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Buckley Baldeschwieler

Address W B G H Date signed 6/25/44 (M. D.)

1040

G 15475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 V

Registered No. G 15475

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st St.

(c) Hospital or institution: U. S. Marine Hospital

Since 6/14/44

15-43

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 4415 Pallmall Rd. (If rural give location)

(e) Citizen of foreign country?: No (Yes or No)

If yes, name country:

3 (a) **FULL NAME** LASOVER, Hyman Harry

3 (b) If veteran, name war: World's War

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9, 1894

8. AGE: Years: 50 | Months: 1 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Washington, D.C. - 7 mos.ago

11. Industry or business: ??

FATHER: 12. Name: Morris Lasover

13. Birthplace: Russia

MOTHER: 14. Maiden Name: Frances ?

15. Birthplace: Russia

16 (a) Informant: Records, U.S.Marine Hosp.

(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-27-44 (month) (day) (year)

(c) Cemetery or crematory: Herring Run

Location: Third Rd. & Bowley Lane

18 (a) Funeral director: Jack Lewis Inc

(b) Address: 1437 E. Balt St.

JUN 27 1944 (Date rec'd by registrar) (b) [illegible] M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: June 25, 1944, at 5:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14, 1944, to June 25, 1944, and that I last saw him alive on June 25, 1944.

Immediate cause of death: Carcinoma of the stomach with extensive metastases in the lungs, liver and diaphragm. — Duration: Unk.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 6/23/44 Exploratory laperotomy

Major findings of operation: As above

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: No

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: [signature]

Address: Baltimore, Md. Date signed: 6/26/44

VS 150

Va-14496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81

Registered No. G 32476

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 7
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N Front St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Rachael Annie Greenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mr Morris Greenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min. 74

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Aaron Goldstein
13. Birthplace Russia

MOTHER
14. Maiden Name Nettie ?
15. Birthplace Russia

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Washington & Belair Rds

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

JUN 27 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1944, at 10 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944, to June 24 1944, and that I last saw h.. alive on June 24 1944.

Immediate cause of death Bilateral Hypostatic pneumonia Toxemia

Duration

Due to Burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 9, 1944 at 1 PM
(c) Where did injury occur? 10 N. Front St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Not Home While at work? No
(e) Means of injury: Burning Match Set Fire to Clothes

23. Signature [illegible]
Address Mercy Hosp Date signed 6/29/44

Approved: Robert Le Gratacap M.D. 6/26/44

G 10472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

Registered No. G 10472

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town give name of township)
(d) Street No. 4015 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Coppola.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md. Gen. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael Coppola.
13. Birthplace New York

MOTHER 14. Maiden Name Evelyn Otter
15. Birthplace Balto Md.

16 (a) Informant Michael Coppola
(b) Address 4015 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bonnley Land

18 (a) Funeral director Sol Levinson Bros.
(b) Address 1124 W. Baltimore

19 (a) (b)
Registrar

JUN 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26 19 44, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 19 44, to 6/26 19 44, and that I last saw h[illegible] alive on 6/26 19 44.

Immediate cause of death Atelectasis — Duration 1 day

Due to Prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William G. Mitchell M. D.
Address Md. Gen. Hosp. Date signed

G 18475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G 18475 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 823 South Linwood AVE.

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 823 South Linwood Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Chychla

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?

16 (a) Informant: Anthony Chychla

(b) Address: 823 S. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/44 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location: Dundalk Avenue.

18 (a) Funeral director: John J. Duda

(b) Address: 2829 Hudson Street

19 (a) (Date rec'd by registrar) (b) Address

VS 150 JUN 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944 at 1 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1943 to June 26 1944, and that I last saw him alive on June 25 1944.

	Duration
Immediate cause of death: Arteriosclerotic	
C. V. Disease.	
Chr Myocarditis.	
Due to: Complicated Fracture	6-10-44
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E A Schumacher M. D.

Address 842 S Eastern Date signed 6-27-44

B 18275 X ✓ G 18276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
9HA

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... D. I. A.
(c) Hospital or institution:
Balto. City Hospital 2612
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Hyde Park, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Joseph J. Hale Jr. (Hejl)

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna Lindeman
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Aug. 23, 1900

8. AGE: Years	Months	Days	If less than one day
43	10	2	..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business .....

FATHER
12. Name Joseph J. Sr.
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Antonia Hundrach
15. Birthplace Czechoslovakia

16 (a) Informant Anna Hejl (Hale)
(b) Address Hyde Park Md.

17 (a) Burial (b) Date thereof 6/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) JUN 27 1944 (Date received by registrar) (b) [signature] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944, at 2:03 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? .....
(d) Means of injury —

23. Signature Arthur J. Lindemann M.D.
Medical Examiner.
Date signed 6/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 10480 ✓ 94a G 10480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 N. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 607 Cathedral St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Washington Perine

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1870

8. AGE: Years	Months	Days	If less than one day
73	8	11	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Elias Glenn Perine
13. Birthplace Balto Md

MOTHER
14. Maiden Name Eliza Washington
15. Birthplace Jefferson Co Va.

16 (a) Informant Mrs Lawrence Perin (sister)
(b) Address 216 N. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Henry H. Lenherr Sons
(b) [illegible] 1944 Oak & Orchard Sts.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25- 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpas M.D.
Medical Examiner.
Date signed 6-26-44.

VS 151

G 18481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1100

Registered No. G18481

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4514 Curtis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Michael Bondonas Bondonas
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-7788

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation Store Digger
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Anthony Bondonas
(b) Address 4515 Curtis Ave

17 (a) Burial (b) Date thereof Jun 28 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location

18 (a) Funeral director Joseph Kaasmakas
(b) Address Washington Blvd

19 (a) JUN 27 1944
(Date rec'd by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/31 1944 to 6/26 1944, and that I last saw h[illegible] alive on 6/26 1944

Immediate cause of death Toxemia - Empyema of Chest - (Left)

Duration

Due to

Due to

Other Conditions Infections of Head and Penis -
(Include pregnancy within 3 months of death)

Date of operation Operated at St. Joseph's Hosp.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Ballweg
Address St. Joseph's Hosp. Date signed 6/26/44
M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 8282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 G 18282

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linthicum Heights
(c) Hospital or institution: University 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Dowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 5 hr. 45 min.

9. Birthplace University Hospital (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name

13. Birthplace N C

MOTHER 14. Maiden Name Ada Watkins

15. Birthplace N C

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUN 21 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 27 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16- 1944 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1944, to 6-16 1944 and that I last saw him alive on 6-16 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address University Hosp. Date signed 6-17-44

VS 150

1047

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Oakleaf Village (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Page

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Baby

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hr. 90 min.

9. Birthplace University Hospital Baltimore Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business Boy

FATHER
12. Name Thomas
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15. Birthplace —

16 (a) Informant —
(b) Address —

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address
JUN 27 1944 Authority for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1944 at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to June 16 1944 and that I last saw him alive on June 16 19 14 11:35

Immediate cause of death Prematurity — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Gubleman, Jr. M. D.
Address University Hospital Date signed June 15, 1944

1048

G 18484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1402

G 18484 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please state correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: Union Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Guilford ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ira B. Morningstar

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Ira L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1879

8. AGE: Years	Months	Days	If less than one day
65	0	27	hr. min.

9. Birthplace Md (Union Bridge)
(Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name John Baker
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Mills
15. Birthplace Md.

16 (a) Informant Mr. Ira L. Morningstar
(b) Address 3220 Guilford Ave.

17 (a) Burial (b) Date thereof 6/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
Registrar

JUN 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1944 to 6-25 1944.
and that I last saw her alive on 6-25 1944.

Immediate cause of death	Duration
Resp. Failure	
Due to Cerebral Edema	
Due to Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6-13
Major findings of operation: Carcinoma of Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address Union Hospital Date signed 6-25-44
Balto Md

M. D. R. 1268-9

G 18485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

108

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 N. Schroeder St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Amelia Atkinson

(a) Residence: No. 227 N. Schroeder St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem.	Col.	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Cleveland Atkinson

6. DATE OF BIRTH (month, day, year) April 27, 1916

7. AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	28	1	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Garner, N.C.

FATHER

13. NAME George McClain

14. BIRTHPLACE (city or town) (State or country) Garner, N.C.

MOTHER

15. MAIDEN NAME Goldie Williams

16. BIRTHPLACE (city or town) (State or country) Garner, N.C.

17. INFORMANT Cleveland Atkinson

(Address) 227 N. Schroeder St.

18. BURIAL, CREMATION, OR REMOVAL

Place Raleigh, N.C. Date June 27, 19 44

19. UNDERTAKER Mrs Katie R. Williams

(Address) 327 N Schroeder St

20. FILED JUN 27 1944 Huntington Williams, Mgr

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 24, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 15, 1944 to June 24, 1944

I last saw h[illegible] alive on June 23, 1944 Death is said to have occurred on the date stated above, at 2:30 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	6-15-44
Other contributory causes of importance: Bronchitis	5-12-44
Hypotension	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) McDonald Bando M. D.

(Address) 2445 Wrenwood Hill Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

v. s. 3

G 8486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

V G 18486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 North Eden St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Gary

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hampton Gary
13. Birthplace North Carolina

MOTHER
14. Maiden Name Estella Crowell
15. Birthplace North Carolina

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location.....

18 (a) Funeral director.....
(b) Address.....

JUN 27 1944
(Date rec'd by registrar)

JOHNS HOPKINS MEDICAL SCHOOL JUN 27 1944

Commissioner of Health
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1944, at 6.12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944, to June 18 1944, and that I last saw her alive on June 18 1944.

	Duration
Immediate cause of death Intrauterine asphyxia; Prematurity	
Due to Maternal: Antepartum hemorrhage; Placenta praevia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-17-44
Major findings of operation: confirmed
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....
(Specify type of place)
While at work?.....
(e) Means of injury.....

23. Signature Philip F. Stepto, Jr. M. D.
Address Johns Hopkins Hospital Date signed 6-23-44

1050

G 18282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G 18282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Edgewood Arsenal (If outside city or town limits, write RURAL and give town)
Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby girl House

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-44

8. AGE: Years | Months | Days | If less than one day: 4 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name Richard House
13. Birthplace
MOTHER
14. Maiden Name Fern Nees
15. Birthplace

16 (a) Informant Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JUN 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date received by registrar) JUN 27 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1944, at 11.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944, to June 21 1944, and that I last saw h.e.r alive on June 21 1944.

Immediate cause of death: asphyxia x salivation — Duration: 5 hrs.
Due to: hypomagnesaemia tetania
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: stomach, small intestine & colon not examined

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Roscoe Kaye M.D.
Address Date signed 6-27-44

1049

C 10488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

C 18488 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution Maryland General Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - H 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Baby Boy Kory

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Kory
13. Birthplace Trenton N.J.

MOTHER
14. Maiden Name Ruth Meyers
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Ruth Kory
(b) Address 21 N Wolfe St Balto Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 27 1944 Hunting for Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1944, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1944 to 6/22 1944, and that I last saw h[illegible] alive on 6/12 1944

Immediate cause of death Bronchopneumonia — Duration 2 hrs

Due to

Due to

Other Conditions Respiratory Failure (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Mitchell M. D.
Address Md. Gen. Hosp. Date signed

1051

G 18469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G 18469

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the c the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Jos. Hosp. 27 N 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3338 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Miss Elizabeth Ruth De Voy

3 (b) If veteran, name war .....
(c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 29-1892

8. AGE: Years	Months	Days	If less than one day
51	10	29	..... hr. ..... min.

9. Birthplace Balto., Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business A. P. Stores

FATHER
12. Name John J. De Voy
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Boyle
15. Birthplace Ireland

16 (a) Informant Mary Ryan
(b) Address 705 Baltimore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29-44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Homeland Ave

18 (a) Funeral director Thos. A. McKean
(b) Address 420 Greenmount Ave

19 JUN 27 1944 (b) .....
(Date rec'd by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1944, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9-1944, to 6-25-1944 and that I last saw her alive on 6-25-1944.

Immediate cause of death Tuberculous peritonitis — Duration .....

Due to Pulmonary Tuberculosis — Duration .....

Due to ..... — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Tubercles on abdominal organs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Frank L. Vanns M. D.
Address St. Jos. Hosp Date signed 6-25-44

G 18490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18490

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 dl.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Register Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anne Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Henry J. Sweeney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/8/1905

8. AGE: Years 39 Months 3 Days 17 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housf.

11. Industry or business

FATHER
12. Name John Adam Linz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Wirnsberg
15. Birthplace Balto. Md.

16 (a) Informant Henry J. Sweeney
(b) Address 621 Register Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date there June 27-44 (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John A. Mahan
(b) Address 4426 Frankford Ave

19 (a) JUN 27 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 1944, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1944 to 6/25 1944 and that I last saw her alive on 6/25 1944

Immediate cause of death: Resp. Failure — Duration

Due to: Hypertensive C-V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. M. N. Crosby Mercy Hosp. Date signed 6/25

G 18491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 18491 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 644 S. Kenwood Avenue

(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Wks.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2419 Fleet Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Bollack

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Christian Bollack

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1874

8. AGE: Years 70 | Months 3 | Days 28 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Single
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Snyder
15. Birthplace Baltimore, Md

16 (a) Informant Mr. Carl W. Borleis
(b) Address 644 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 -28 -44 (month) (day) (year)

(c) Cemetery or crematory First Evangelical Church Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address North Ave & Broadway

19 (a) (b) Huntingdon Pennsylvania, Md.

JUN 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June, 25 1944, at 5.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1941 to June 25 1944 and that I last saw her alive on June 24 1944

Immediate cause of death: Metastatic Carcinoma Cerebrum — Duration: 1½ yrs.

Due to Carcinoma Breast — Duration: 6 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Karl Grossman M. D.

Address 1212 N. Patterson Pk Ave Date signed 6/26/44

G 18492 G 18492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V135B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Street
(c) Hospital or institution:
Hosp. for Women of Maryland 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts
(If rural give location)
(e) Citizen of foreign country? + 39 Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. James

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife Richard E. James | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1883

8. AGE: Years 60 | Months 96 | Days 25 | If less than one day 20 hr. 20 min.

9. Birthplace Dorchester County Maryland (Town, county and state)

10. Usual Occupation Manager of Dining Room

11. Industry or business

FATHER 12. Name Samuel Stafford

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Stafford

15. Birthplace Md

16 (a) Informant Wolford Griffith and

(b) Address Hospital Record

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Woodlawn, Balto. Md.

18 (a) Funeral director John A. Mitchell & Son

(b) Address 1900 Eutaw Place

(c) 6-27-44 (Date rec'd by registrar) [illegible] (By)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1944 at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 1944 to 6-25 1944 and that I last saw her alive on 6-25 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Post Operative Pneumonia - Recovered
(Include pregnancy within 3 months of death)

Date of operation 6-13-44

Major findings of operation: Infected Vaginal cuff

of autopsy: Cystocele Rectocele

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.

Address Women's Hospital Date signed 6/25/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BEGIN RESERVED FOR BINDING

G 1845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G 18493

Registered No. 9-18493

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 144 S. HIGHLAND AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 144 S. HIGHLAND AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AGNES HAGAN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 212 09 2885
4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: CHARLES HAGAN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) DEC. 10 1876
8. AGE: Years 67 | Months 6 | Days 14/15 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation SEAMTRESS
11. Industry or business

FATHER
12. Name LAWRENCE McHUGH
13. Birthplace IRELAND

MOTHER
14. Maiden Name ANNA KNIGHT
15. Birthplace IRELAND

16 (a) Informant CHARLES HAGAN (SON)
(b) Address 144 S. HIGHLAND AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/28/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly & Zeiler Chas.
(b) Address 403 S. WOLFE ST.

19 (a) JUN 27 1944 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JUNE 25 1944 at 1/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1940 to June 25 1944 and that I last saw h[illegible] alive on June 25 1944.

Immediate cause of death: Chronic Myocarditis — Duration
Due to: Hypertension — Duration
Due to: Arteriosclerosis — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Joseph Lankey M. D.
Address 441 S. Ellwood Ave Date signed 6/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3639 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3639 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Horvat

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1886

8. AGE: Years 58 | Months 4 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation
11. Industry or business Manf, Jewelery Retail

FATHER
12. Name Morris Kohn
13. Birthplace Hungary

MOTHER
14. Maiden Name Rosalie Aszody
15. Birthplace Hungary

16 (a) Informant Mrs Irene Horvat
(b) Address 3639 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemerty
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date received) JUN 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jnue 26, 1944, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to June 26 1944, and that I last saw him alive on June 26 1944.

Immediate cause of death — Duration

Due to Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
1944
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 203 Patapsco Date signed

G 1845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

Registered No. G 1845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon of America 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 751 W. LEXINGTON St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DARIA MAE Ashwell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 25, 1944

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name CURTIS Ashwell
13. Birthplace Bedford Co. Va.

MOTHER
14. Maiden Name NORMA MARTIN
15. Birthplace ABILENE KANSAS

16 (a) Informant Norma Ashwell
(b) Address 751 W Lexington St

17 (a) Removal (b) Date thereof 6-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Huddleston, Va.

18 (a) Funeral director Wm. J. Tickner & Sons Baltimore, Md.
JUN 27 1944
(Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 27 1944, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1944 to 6/27 1944 and that I last saw her alive on 6/26 1944.

Immediate cause of death: Congenital Atelectasis — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Dorsey
Address 2511 Riverside Dr. Date signed 6/27/44

G 18496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G 18496 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 E. Preston Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 E. Preston St
(If rural give location)
(e) If foreign born, how long in U. S. A.? 65Yrs. years

3 (a) FULL NAME Anne O'Neill

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1864

8. AGE: Years 80 | Months 0 | Days 24 | If less than one day ######## min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Felix O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane ### Shorten
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine Lyons
(b) Address 2934 Greenmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave., Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JUN 27 1944 (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1944, to June 26 1944 and that I last saw h[illegible] alive on 6/24/44 1944.

Immediate cause of death: Coronary Thrombosis (2) — Duration: sudden

Due to: Coronary Artery Sclerosis — Duration: 2 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature J. Karl Lionman M. D.

Address 1212 N. Patterson Date signed 6/26/44

Re Ove

G 18497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G 18497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in Hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty E. Harden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 28 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Hermen Hill Rd

18 (a) Funeral director Lilly & Zeile
(b) Address 1901 Chester Ave

19 (a) JUN 27 1944 (Date rec'd by registrar) (b) Huntingdon Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1944 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of liver

Due to Chronic Alcoholism

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 27 1944

VS 151

G 18498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G 18498 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bethlehem-Fairfield Shipyards
(c) Hospital or institution: Key Highway
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Frank

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 208-03-9446

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Eleana Adams

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept 12. 1893

8. AGE: Years	Months	Days	If less than one day
50	9	14	hr. min.

9. Birthplace: Leben W. Va (Town, county, and state)

10. Usual Occupation: Rigger

11. Industry or business: Shipyard

FATHER
12. Name: Wm H Frank
13. Birthplace: W. Va

MOTHER
14. Maiden Name: Rachel Farmer
15. Birthplace: W. Va

16 (a) Informant: Mrs Jas. Frank
(b) Address: 723 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory: Leben W. Va
Location: Leben W. Va

18 (a) Funeral director: Thos J. Kenny
(b) Address: Hollins & Gilmor

19 (a) JUN 27 1944 (Date received by registrar) Wm. J. Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 11:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 26 1944 11:15 A.M.
(b) Where did injury occur? Pier #7 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Fell off ship onto pier

23. Signature: Robert L. Gaston M.D. Medical Examiner.
Date signed: June 26 1944

G 18499

AB-88635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133 G 18499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Odell or Adell Gilmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elijah Gilmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1907

8. AGE: Years 37 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Moore
13. Birthplace Virginia

MOTHER
14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 Huntington Ave Baltimore, Md

19 JUN 27 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1944, at 12:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1944, to 6-25 1944, and that I last saw h[illegible] alive on 6-25 1944.

Immediate cause of death	Duration
Uremia	?
Due to Pyelonephritis	?
Due to	
Other Conditions Carcinoma of Cervix with Pregnancy (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathews
Address B.C.H. Date signed 6/28/44

G 18500 ~~B-88656~~

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310

G 18500 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Lee St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Ivey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17- 1896

8. AGE: Years	Months	Days	If less than one day
47	6	9	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Vernon Ivey (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Lena Bowser
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Richmond
Location Virginia
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3221 Sahlgreen St Huntington Station, Md.
19 (a) JUN 27 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26- 1944, at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1944 to 6-26 1944, and that I last saw h[illegible] alive on 6-26 1944.

Immediate cause of death	Duration
Uremia	7
Due to Nephrosclerosis	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hettne M.D.
Address B.C.H. Date signed 6/26/44

CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 18502
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Motherhouse of Notre Dame 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. Quirilla Reuter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1859

8. AGE: Years 86 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Religious

FATHER
12. Name John G. Reuter
13. Birthplace Germany

MOTHER
14. Maiden Name Frances Schueler
15. Birthplace Germany

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 1944 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glenn Arm.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N. Wolfe. St

19 (d) JUN 27 1944 (Date rec'd by registrar) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 1.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1927, to June 25 1944, and that I last saw her alive on June 25 1944.

Immediate cause of death: Arterio Sclerosis — Duration

Due to: Myocarditis

Due to: Hypertension Cerebral Hemorrhage

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence — at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Stirling M.D.
Address Baltimore 2 Md. Date signed 6/27/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 18502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G 18502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: U. S. Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Mos

2. USUAL RESIDENCE OF DECEASED
(a) State Mich (b) County Bay City
(c) City or town Baltimore Michigan (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S. Jackson St (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Richter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1914

8. AGE: Years	Months	Days	If less than one day
30	5	20	hr. min.

9. Birthplace Bay City Michigan (Town, county, and state)
10. Usual Occupation Seaman 1/C
11. Industry or business U. S. Coast Guard

FATHER
12. Name Emil L. Richter
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant U. S. Coast Guard
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-44 (month) (day) (year)
(c) Cemetery or crematory
Location Bay City Michigan

18 (a) Funeral director Roff & B. M. Walker
(b) Address Preston & Lucke Sts

19 (a) JUN 27 1944 (Date rec'd by registrar) (b) Huntington Williamsport Pa

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26-44 19 44, at 2A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure
Acute Pulmonary Edema
Due to
Other Conditions Acute Congestion of Viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 6-26-44

PLEASE WRITE PLAINLY, with unfading ink. Every item should be answered. Where information is unknown or not applicable, write the word "unknown" or the abbreviation "N. A." Be sure to state the correct age in years, months, days, hours, or minutes. Do not report fractions of years. Report the causes of death clearly and legibly. Physicians: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asphyxia, anemia, etc. Be sure that the cause of death is especially important.

G 18503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

Registered No. G 18503

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene Sts.
(c) Hospital or institution: University Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 27 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Moreland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs Pauline Rohse Barten~~ Pauline Marie Lohse Barten

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: Female

5. Color or race: White

6 (a) Single, married, ~~widowed~~, or divorced. Widowed

6 (b) Name of husband or wife: Frederick H. Barten

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 1, 1896

8. AGE: Years	Months	Days	If less than one day
47 48	5 0	24	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business At Home

FATHER
12. Name George Lohse
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Schell
15. Birthplace Germany

16 (a) Informant Son, Mr. Henry John Barten
(b) Address 1518 Moreland Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Newport News, Va.

18 (a) Funeral director E. W. Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) Signature (Local Registrar) (b) Date received JUN 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1944 at 1.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1944 to 6-25 1944 and that I last saw her alive on 6-25 1944.

Immediate cause of death	Duration
Mediastinal Shift & Hydrothorax, Pul. Edema	3 mo
Due to Carcinomatosis	
Due to 1° Ca of st breast.	19 mo.
Other Conditions Anemia	6 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Carpenter M. D.
Address Mercy Hosp Date signed 6/25/44

Continued

Ebert

G 18504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G 18504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 McHenry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Bertha Ebert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1875

8. AGE: Years 69 | Months 2 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Fredericksburg Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name August Ebert
13. Birthplace Germany

MOTHER
14. Maiden Name Louise LeBulle
15. Birthplace Germany

16 (a) Informant Mrs. Emma Pearl
(b) Address 432 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28-1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

19 (a) (Registrar) Hermione V. Williams, M.D. Registrar

JUN 27 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1944 at 11 35 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Grafton M.D.
Medical Examiner.
Date signed June 26 1944

18505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G 18505

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 569 Oxford St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3. (a) FULL NAME Gertrude Graves

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 28 | Months | Days | If less than one day hr. min.

9. Birthplace Eastover S.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Wife

FATHER
12. Name Clarence Simons
13. Birthplace Eastover S.C.

MOTHER
14. Maiden Name Minnie Taylor
15. Birthplace Eastover S.C.

16 (a) Informant Clarence Simons
(b) Address 1730 McCulloh

17 (a) June 29 44 (b) Date thereof 6/29/44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt Winans

18 (a) Funeral director Chas H. Alexander
(b) Address 1200 McCulloh

19 (a) JUN 28 1944 (b) Date received Thomas E. Millspaugh

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given and the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 5 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to P.M. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 29, 1944

G 18505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18505 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 Horton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo./

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Horton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Matilda Brosius

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1872

8. AGE: Years 71 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Sholly
13. Birthplace Pa.

MOTHER
14. Maiden Name Susanna Stahl
15. Birthplace Pa.

16 (a) Informant Francis G. Brosius
(b) Address 3512 Horton Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/28/44 (month) (day) (year)
(c) Cemetery or crematory Shamokin Pa.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Signature of registrar) (b) Registrar

JUN 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1943 to June 27 1944, and that I last saw her alive on June 27 1944.

Immediate cause of death: Uremia — Duration
Due to: Hypertension
Due to: Disease
Other Conditions: Diabetes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 203 Calaper Date signed

C 18502 ✓ C 18502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 E. 29th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 E. 29th St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Lutz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Fred'k H. Lutz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 26 1859

8. AGE: Years 84 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name John Helwig
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Reinhardt
(b) Address 1902 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director F. S. Wiseburt Son
(b) Address 130 Eastern Ave

19 (a) [illegible] (b) [illegible] Registrar

JUN 28 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26th 1944, at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944, to June 26 1944, and that I last saw her alive on June 25 1944

Immediate cause of death	Duration
Mitral Regurgitation Decompensation	10 Days
Due to Arterio Sclerosis Hypertension	10 d.
Due to Chronic Interstitial Nephritis	10 d.
Other Conditions Arteriosclerosis	14 yr.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 2818 Harford Rd Date signed 6/27/44

4564448508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

✓ G 18508 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 N Chester (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS MINNICK

3 (b) If veteran, name war World War I.

3 (c) Social Security Account No. 218-03-2295

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Elsie

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 4-7-94

8. AGE: Years 50 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation MAINTANENCE MAN

11. Industry or business

FATHER 12. Name William Minnick
13. Birthplace Md

MOTHER 14. Maiden Name Emma Sheeham
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 28 1944 Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 855 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1944, to June 26 1944, and that I last saw him alive on June 26 1944

Immediate cause of death	Duration
lymphosarcoma	8 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cenecer M. D.

Address 346 Date signed 6-26

G 18502 ✓ G 18502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 2018 Kennedy Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Levanis

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4373

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 15 1888

8. AGE: Years 56 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Operator Dice plant
11. Industry or business Dice Hotel

FATHER
12. Name Gregory Levanis
13. Birthplace Greece

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Fay Tricus
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Am.
Location Baltimore Md.

18 (a) Funeral director J. Francis Reese
(b) Address [illegible]

19 (a) JUN 28 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1944, at 4 45 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Chester J. Schmidt M.D. Medical Examiner.
Date signed 6/25/44

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 18510 ✓ G 18510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mount Washington
(c) Hospital or institution:
Mount Saint Agnes Convent 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. St. Agnes Convent
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Raphael Herlichy, R.S.M.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1862

8. AGE: Years 81 | Months 6 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER — 12. Name Michael Herlichy
13. Birthplace Ireland

MOTHER — 14. Maiden Name Catherine ---------
15. Birthplace Ireland

16 (a) Informant Mt. St. Agnes Convent Records
(b) Address Mount Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. St. Agnes Cem.
Location Mt. Washington

18 (a) Funeral director H. W. Meanstow
(b) Address 805 N. Calvert St.

19 (a) [illegible] (b) [illegible]
JUN 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 7.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to June 27 1944 and that I last saw h[illegible] alive on 27 1944.

Immediate cause of death: Mitral insufficency — Duration: 5yrs

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Nursten M. D.
Address 1707 Eutaw Pl Date signed 6/28/44

G 18511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G 18511 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar W. Johnson

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Le.	Married

6 (b) Name of husband or wife Maude Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Baltimore City

MOTHER
14. Maiden Name Marie Bailey
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Maude Johnson
(b) Address 1819 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Maryland

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26-44 19 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1944 to 6-26- 1944, and that I last saw him alive on Jun 8, 1944

Immediate cause of death Coronary Thrombosis — Duration 14 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey Thomas M. D.
Address 312 E 23rd St Date signed 6 27 44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G 18512
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fauntleroy

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	S

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 | 13 | 43

8. AGE: Years	Months	Days	If less than one day
1	5 17	11	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Child
11. Industry or business

FATHER
12. Name: Amassa Fauntleroy
13. Birthplace: Md.

MOTHER
14. Maiden Name: Christine Hayes
15. Birthplace: Md.

16 (a) Informant: Amassa Fauntleroy
(b) Address: 2425 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: Md.

18 (a) Funeral director: George G. Kelson
(b) Address: 1303 Pressmen St.

JUN 28 1944 (Date rec'd by registrar)

Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944, to June 27 1944, and that I last saw h.i.c. alive on June 24 1944.

Immediate cause of death: T.B. Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 6/26/44 T.B. Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. J. Burgess M. D.
Address Provident Hospital Date signed 6/27/44

VS 150

G 18513

JL - 70709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

G 18513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospital
3 - 6- 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

27-17

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Beltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Belvedere Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George McCauley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name John
13. Birthplace Md.

MOTHER
14. Maiden Name Susy Phillips
15. Birthplace ?

16 (a) Informant B. C. H/ Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 - 28 - 44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Young Byers
(b) Address 5005 Park Heights Ave

19 (a) JUN 28 1944 (Date rec'd by Registrar) (b) [illegible] M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 6:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1941 to June 26 1944 and that I last saw h[illegible] alive on June 26 1944

Immediate cause of death Pulmonary Edema — Duration 7

Due to Coronic Failure — ?

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno J Dempsey M. D.
Address Balto City Hosp Date signed June 26 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1146C

G 18514 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden 27
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 605 McCabe Ave 10 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Duitscher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Elmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7 1907

8. AGE: Years	Months	Days	If less than one day
36	9	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Ida Harbaugh
15. Birthplace

16 (a) Informant Elmer T. Duitscher
(b) Address 605 McCabe Ave.

17 (a) Burial (b) Date thereof June 29 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Roland L. Fisher
(b) Address 500 S. Park Heights Ave.

JUN 28 1944 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26 1944 at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1944 to 6-26 1944 and that I last saw h. er alive on 6/26 1944.

Immediate cause of death: Cardiac Failure — Duration: 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 6-17-44 & 6-23-44

Major findings of operation: 6-17 - Returned Saundes - 6-24 - Cholecystectomy

of autopsy: Nothing of Note Drawn

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William G. Mitchell M. D.

Address Md. Gen. Hosp. Date signed

G.C.P. 18515 88319

G 18515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G 18515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Parkwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Knabe (Minnie Estella Knabe)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry Knabe (d)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 27, 1883

8. AGE: Years 61 | Months 2 | Days 0 | If less than one day: hr. min.

9. Birthplace: Maryland (Balto.)
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: John W. Jones
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Adeline Rempell
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date r... JUN 28 1944 ... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1944 19 , at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944, to 6-27 1944, and that I last saw h... alive on 6-27 1944.

Immediate cause of death: Carcinoma of breast with metastasis — Duration: ?

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Paul Mathna M.D.
Address: B.C.H. Date signed 6/27/44

A36209
G 18512

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 18512

CERTIFICATE OF DEATH 1318

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Crescent City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Huber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-42

8. AGE: Years	Months	Days	If less than one day
2	-	17	hr. min.

9. Birthplace Fla. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name E. S. Huber
13. Birthplace Wis.

MOTHER
14. Maiden Name Kathryn Houchins
15. Birthplace Ohio

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-44 (month) (day) (year)
(c) Cemetery or crematory Mr. James E. Huber
Location Melbourne, Fla.

18 (a) Funeral director J. G. Mitchell Co.
(b) Address 120 Center St

19 (a) (Date rec'd by registrar) (b) Address Melbourne, Fla.

VS 15c JUN 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944 at 7 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1944, to June 27 1944, and that I last saw h. im alive on June 27 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertension	2 mo
Due to Chronic Nephritis	2 mo
Other Conditions terminal aspiration of vomitus. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Jay Osborn M.D. M. D.
Address Date signed

G 18512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18512 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3327 Lyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Rohlfing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Anna L Rohlfing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15. 1883

8. AGE: Years	Months	Days	If less than one day
60	9	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Balto Transit Co.
11. Industry or business

FATHER
12. Name John M Rohlfing
13. Birthplace Baltimore

MOTHER
14. Maiden Name Paloma Snyder
15. Birthplace Baltimore

16 (a) Informant Frederick C Rohlfing Jr
(b) Address 3327 Lyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30- (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

VS JUN 28 1944

MEDICAL CERTIFICATION 20

20. DATE OF DEATH June 27 1944 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1944 to 6-27 1944 and that I last saw him alive on 6-27 1944.

Immediate cause of death Chronic myocarditis & decompensation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 6-27-44

C 10515 C 10515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5809 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5809 Park Heights Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME BERNARD S. GOMPRECHT.

3 (b) If veteran, name war: 1st. World War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Gomprecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1895.

8. AGE: Years 49 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Sigmund Gomprecht,
13. Birthplace New York.

MOTHER
14. Maiden Name Rose E. Goodman,
15. Birthplace New York.

16 (a) Informant Mr. Bernard Lutzky,
(b) Address Alhambra Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/44. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Sol. Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 JUN 28 1944 (Date received) (Signature)

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th. 1944, at 8.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 19 , to June 27 1944 and that I last saw h alive on June 27 19 44.

Immediate cause of death	Duration
coronary occlusion	sudden
Due to coronary sclerosis	8 yrs
Due to diabetes mellitus	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis Lutzky M. D.
Address 1720 Eutaw Place. Date signed 6.27.44

4 G 18518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 18518
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 N Mount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LeRoy Yates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-23-42

8. AGE: Years	Months	Days	If less than one day
1	7	4	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name LeRoy Yates
13. Birthplace Md

MOTHER 14. Maiden Name Mildred Jones
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 6-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Balto. Md
18 (a) Funeral director Archibald B Gaddis
(b) Address 201 McCulloh St.
19 (a) JUN 28 1944 Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 435A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944, to June 27 1944, and that I last saw h IM alive on June 27 1944

Immediate cause of death: Tuberculous meningitis — Duration: 4 wks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature a. j. Warring jr. M. D.
Address Hopkins Date signed 6-29-44

G 18520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

129

G 18520 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland 4
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital of inst. (yrs., mos., or days) 8 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 219 East Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widow

6 (b) Name of husband or wife William H. Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant William Stewart
(b) Address 219 Pearl St

17 (a) Burial (b) Date thereof June 28, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

JUN 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26- 1944, at 1:15 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Diffuse Peritonitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 6-26-44

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 18521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 18521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Dulaneys
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Glory Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred D. Burnup.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-3505

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20 1891

8. AGE: Years 52 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Safety Engineer

11. Industry or business

FATHER
12. Name John C Burnup
13. Birthplace Md

MOTHER
14. Maiden Name Kate Lowery
15. Birthplace Md

16 (a) Informant Mrs Bertha Burnup
(b) Address 3631 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location East North Ave

18 (a) Funeral director Wm M Marsch
(b) Address 765 E Lanvale St

19 (a) JUN 28 1944 (Date rec'd by registrar) Thurlington McManus, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 12 40 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed June 27, 1944

PLEASE WRITE PLAINLY. Fill in all blanks with typewriter or pen and ink. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18522
Registered No.

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light nr. West St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 S. Conkling St (If rural give location)
Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shiflett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1944

8. AGE: Years | Months | Days | If less than one day: 8 hrs. hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Norman L. Shiflett
13. Birthplace Virginia

MOTHER — 14. Maiden Name Irene A. Phelps
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 28 1944 (Signature and title) Huntington Williams M.D.

VS 150

1033

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1944 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1944, to 6-18 1944, and that I last saw him alive on 6-18 1944.

Immediate cause of death	Duration
Anoxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Burns Tyson M.D.
Address South Balt. Gen. Date signed 6-18-44 M. D.

18523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G 18523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 N Chapel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give township)
(d) Street No. 1309 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Brady

3 (b) If veteran, name war: Yes
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-1897

8. AGE: Years	Months	Days	If less than one day
44	11	14	hr. min.

9. Birthplace N C
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Robert Brady
13. Birthplace N.C.

MOTHER
14. Maiden Name Amanda Butler
15. Birthplace N.C.

16 (a) Informant Clarence Brady
(b) Address 1022 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McCulloh St

JUN 28 1944 (Date rec'd by registrar) Hamilton Station Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 44 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 19 44 to 6/25 19 44
and that I last saw h alive on 6/25 19 44
Immediate cause of death: Lobar Pneumonia — Duration 7 days
Due to: Exposure & Colds
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave. Date signed 6/27/44

G 18524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. G 18524

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME General Costin

3 (b) If veteran, name war —

3 (c) Social Security Account No. Widowed —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife Late Nora E. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1861

8. AGE: Years	Months	Days	If less than one day
82 83	10,	17	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Met. Life Ins. Co.

FATHER
12. Name James V. Costin
13. Birthplace - N.C

MOTHER
14. Maiden Name Harriet C. Bowie
15. Birthplace - N.C.

16 (a) Informant Miss Evelyn Costin
(b) Address 1802 W. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 Edmondson Ave.

19 (a) JUN 28 1944 (Date rec'd by registrar) Hunter Jr Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25- 1944, at 9 45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Fractured ribs
Fractured femur.

Other Conditions Blunt trauma, bruises abrasions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-25- 1944 at 5.30P M.
(b) Where did injury occur? Balto. St. W. of Gilmor
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Street Car.

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 6-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 151

G 18525

SCURTO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195B

G 18525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (If not in hospital) Monument & Wolfe Sts.
(c) Hospital or institution: Sinai Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. SCURTO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Margaret Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1915

8. AGE: Years	Months	Days	If less than one day
28	9	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Own Business

FATHER
12. Name Angelo Scurto
13. Birthplace Italy

MOTHER
14. Maiden Name Myrtle
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret L. Scurto
(b) Address 1203 Glyndon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Harry H. Wiltke
(b) Address 1101 Edmondson Ave

JUN 28 1944 (Date rec'd by registrar) Huntley-Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1944 to 6-27 1944 and that I last saw h[illegible] alive on 6-27 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic Heart Disease	
Other Conditions Small Pulmonary Infarction	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dwayle
Address Sinai Hosp. Date signed 6-27-44 M.D.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

18526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18526 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 Booth Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Booth Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Gertrude Mueller

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Herman Mueller
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) October 10, 1886

8. AGE: Years 58 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick E. Kaminsky
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Dotzman
15. Birthplace Germany

16 (a) Informant Herman Mueller
(b) Address 2115 Booth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George D. Schwab
(b) Address 2101 Frederick Avenue

19 (a) (Date received by local registrar) (b) Huntingdon Williams, M.D.

JUN 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 6/27 1944, and that I last saw her alive on 6/27 1944

Immediate cause of death Carcinoma of Uterus — Duration 6 yrs.
Due to Metastasis
Due to
Other Conditions (Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinoma
of autopsy: Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Reamy M. D.
Address 245 W. Belvedere Ave. Date signed

256237

12522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 18522

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Whiteford
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Jule Hunt Blake

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-11-44

8. AGE: Years	Months	Days	If less than one day
	2½	17	hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Arnold Blake
13. Birthplace W. Va.

MOTHER
14. Maiden Name Annette Friel
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/44 (month) (day) (year)
(c) Cemetery or crematory State Ridge
Location Delta Pa
18 (a) Funeral director Robert P Hunter
(b) Address Delta Pa.
19 (a) JUN 28 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944 at 7.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944 to June 28 1944 and that I last saw him alive on June 28 1944.

Immediate cause of death Respiratory Failure
Due to Pulmonary
Due to .....
Other Conditions Pneumonia emphysema
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

Duration: Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury Robert Hunter
23. Signature J H H Date signed 7/4/44
Address .....

VS 150

G 18528

Beches

AB-88505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G 18528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct spelling. Be sure to write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 N. Castle Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Cech (Chek)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1905

8. AGE: Years	Months	Days	If less than one day
39	5	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name Joseph Cech
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Tena Schotowitz
15. Birthplace Czechoslovakia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Ovach & Son
(b) Address 900 N. Chester St-5

19 JUN 28 1944 (Date rec'd by registrar) Hartley H. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25- 1944, at 7.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1944 to 6-25 1944 and that I last saw h[illegible] alive on 6-25 1944

Immediate cause of death: For advanced Tuberculosis may Tuberculosis — Duration: -
Due to — Duration:
Due to — Duration:
Other Conditions — Duration:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathews M. D.
Address B.C.H. Date signed 6/26/44

G 18529 ✓ G 18529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Woodlawn Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
-14
(d) Street No. 506 Woodlawn Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Wardlaw Miles

3 (b) If veteran, name war 1917-18
3 (c) Social Security Account No.
4. Sex M
5. Color or race Wh.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Katherine Stockton Miles
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) March 23, 1873
8. AGE: Years 71 Months 3 Days 4 If less than one day — hr. — min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation College Professor
11. Industry or business. Johns Hopkins

FATHER
12. Name Francis T. Miles
13. Birthplace near Charleston, S.C.

MOTHER
14. Maiden Name Jeanie Wardlaw
15. Birthplace Abbeville, S.C.

16 (a) Informant Francis T. Miles (son)
(b) Address 506 Woodlawn Road, Balto.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave, Balto.
18 (a) Funeral director Henry T. Jenkins, Sons & Co.
(b) Address Belair & Orchard Sts
JUN 29 1944
(Date rec'd by registrar) Hunting for Wilkinson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1943 to June 27 1944 and that I last saw h alive on June 27 1944,

Immediate cause of death Carcinoma of Pancreas
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Duration 9 mos.

Date of operation Nov. 1, 1943.
Major findings of operation: Carcinoma of the Pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Q. Murray Fisher M. D.
Address 18 E. Eager St. Date signed 6/28/44
Baltimore.

VS 150

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

G 13530

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Warrington Apartments
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-1
(e) Length of stay in Baltimore (yrs., mos., or days) 9 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mayland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Warrington Apartments 3908 N. Charles (Specific location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Sophie Barclay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William Geo Barclay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1854

8. AGE: Years	Months	Days	If less than one day
90	1	4	hr. min.

9. Birthplace Pittsville Pennsylvania (Town, county, and state)
10. Usual Occupation home wife
11. Industry or business home.

FATHER
12. Name George Kaplener
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Sophie (Kaplener) Bely
15. Birthplace Pennsylvania

16 (a) Informant Beatrice Barclay Olver
(b) Address Pittsville Wyoming Co. Penn.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 29 44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location New York N.Y.

18 (a) Funeral director Henry M. Jenkins Sons & McCulloh & Orchard Sts
(b) Address

19 (a) JUN 29 1944 (Date received by local registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 1944, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20th 1943, to June 28th 1944, and that I last saw h[er] alive on June 28th 1944.

Immediate cause of death Cardiac Decompensation — Duration 8 months

Due to Arthritis - Senility — Duration about years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. M. Dabney M. D.
Address Reston, Baltimore 4 Md. Date signed June 28th 1944

G 18531 ✓ G 18531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5007 Norwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5007 Norwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Tabitha Smiley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6 1856

8. AGE: Years 87 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name James Smiley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Isabella Greenwood
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Paul Clifford
(b) Address 5007 Norwood Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 29 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore Md

18 (a) Funeral director E. Miller Sawyer
(b) Address 1510 Lafayette Heights Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 29 1944 Huntingdon, Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941 to June 26 1944 and that I last saw her alive on June 24 1944.

Immediate cause of death: Heart Failure (Old age)

Due to: Arteriosclerotic Cardio Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 yrs
15 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas T. Abbott M. D.
Address 4509 Liberty Heights Ave Date signed 6-29-44

G 1853 ✓ G 1853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4807 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Paul Spyr

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace Corinne Spyr
6 (c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): November 17, 1866
8. AGE: Years 77 | Months 7 | Days 10 | If less than one day: hr. min.
9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Mr. Spyr
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. William Spyr
(b) Address: 5120 Howard Park Ave.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof: June 29,1944 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Pk. Cem. Mausoleum
Location: Woodlawn, Md.

18 (a) Funeral director: Miller Lamborn
(b) Address: 4510 Liberty Heights Ave.

19 (a) Date received by Registrar: JUN 29 1944 (b) Hartzler Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 3.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1944 to June 27 1944, and that I last saw him alive on June 26 1944

Immediate cause of death: Cerebral Vasc Accident — Duration: 9 days
Due to: Arteriosclerotic Cardio Vasc
Due to: Dubois
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos H Robert M. D.
Address 4509 Liberty Hgts Ave. Date signed

G 18533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G 18533 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Wilkens & Caton Ave
(c) Hospital or institution St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 25+

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Benson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Carroll Pundt

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-6054

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary M. Pundt

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec. 17 1903.

8. AGE: Years	Months	Days	If less than one day
40	6	26	hrs. min.

9. Birthplace Baltimore Md
(Town, county, or state)
10. Usual Occupation General Yard Inspector
11. Industry or business B&O R.R.

FATHER
12. Name George A. Pundt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Spear
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Mary M. Pundt
(b) Address 3407 Benson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30/44 (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore Md

18 (a) Funeral director Willis L. Amoroso
(b) Address 410 Liberty Heights Ave

19 (a) (Date received by Local Registrar) JUN 29 1944

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1944 at 10:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 6-27 1944 and that I last saw him alive on 6-27 1944

Immediate cause of death: Peritonitis

Due to: Gastric Fistula

Due to: Ruptured Peptic Ulcer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-2-44

Major findings of operation: Ruptured Peptic Ulcer

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.
Address St. Agnes Hosp Date signed 6/27/44

G 18534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 18534
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2868 Harford Road
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2868 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN BEARDSLEY BENNETT

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Owen S. Bennett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1904

8. AGE: Years	Months	Days	If less than one day
40	5	10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Technician
11. Industry or business Mine Safety Appliance Co.

FATHER
12. Name Ethan Allen Beardsley
13. Birthplace Balto.

MOTHER
14. Maiden Name May Padgett
15. Birthplace Balto.

16 (a) Informant Mrs. Asa V. Wright
(b) Address 2868 Harford Ave.

17 (a) Burial (b) Date thereof 6/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) JUN 29 1944 (b) M. Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1944, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18-1943 to 6-27-1944 and that I last saw her alive on 6-26-1944

Immediate cause of death	Duration
Carcinoma breast	2 yrs.
Due to (with metastases)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1½ yrs
Major findings of operations Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. B. Sybert M. D.
Address 702 Harford Rd Date signed 6-28-44

G 10535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 10535

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 Division Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Division Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elisa C. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 1863

8. AGE: Years	Months	Days	If less than one day
80 79	7		hr. min.

9. Birthplace Fredrick Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Betsy Butcher

15. Birthplace Fredrick, Maryland

16 (a) Informant Flora Malle

(b) Address 1236 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (month) (day) (year)

(c) Cemetery or crematory

Location Fredrick, Maryland

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Avenue

JUN 29 1944 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 26 1944 and that I last saw h[illegible] alive on June 26 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardio Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 805 N. Eutaw Date signed June 28

G 18536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G 18536

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Mc Mechen st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Marsh. Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-4-1944

8. AGE: Years — | Months 1 | Days 23 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Willie Marsh
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Jeggets
15. Birthplace Md

16 (a) Informant Willie Marsh
(b) Address 518 Mc Mechen st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

JUN 29 1944 Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28/1944, at 2 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27/1944 to 6/28/1944, and that I last saw him alive on 6/27/1944.

Immediate cause of death Postoperative shock — Duration

Due to Reduction of Impacted right Direct Inguinal Hernia

Due to Fecal Impaction Intestinal Obstruction

Other Conditions Malnourished Dehydrated

(Include pregnancy within 3 months of death)

Date of operation 6/27/44

Major findings of operation: Small intestine protruding through right direct inguinal ring

of autopsy:

PHYSICIAN Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. S. Jackson
Address Provident Hosp. Date signed 6/28/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12018 G 18537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Driveway and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Sarah Anne Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHNSON, WILLIAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	col.	married

6 (b) Name of husband or wife ~~William~~ Estelle Johnson
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) February 20, 1895

8. AGE: Years	Months	Days	If less than one day
49	4	4	hr. min.

9. Birthplace WILMINGTON, NORTH CAROLINA
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business XXXXXXXXXX

FATHER
12. Name William Johnson
13. Birthplace Wilmington, N. C.

MOTHER
14. Maiden Name CATHERINE
15. Birthplace WILMINGTON, N. C.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md.

18 (a) Funeral director Charles B. Cooper
(b) Address 5724 E. Carrollton Ave

19 (a) JUN 29 1944 (Date received) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1944, 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12, 1944, to June 24, 1944, and that I last saw him alive on June 24, 1944.

Immediate cause of death	Duration
Early gangrene of the ileum	Unk.
from old dense adhesions (Intestinal	
~~XXXXX~~ obstruction) ; Multiple	
ulcerations of the ileum,	
~~XXXX~~ cause undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address US Marine Hospital, Baltimore, Maryland Date signed 6/24/44

G 18538 ✓ G 18538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ho
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 555 W. 36th St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes M. Cornell

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Phillip Cornell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1-1878

8. AGE: Years 66 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER — 12. Name Alexander Riley
13. Birthplace Maryland

MOTHER — 14. Maiden Name Lou French
15. Birthplace Maryland

16 (a) Informant Mrs. Helen A. Diven
(b) Address 865 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Guyer Funeral Home
(b) Address 3631 Falls Rd

19 (a) JUN 29 1944 (Date rec'd by local Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic gastric ulcer

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E. Gratz M.D. Medical Examiner.
Date signed June 27, 1944

G 18539

J1 - 88507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G 18539

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.,

(c) Hospital or institution: Baltimore City Hospital 8-16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1622 E. Lanvale St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Charles Mouse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Georgia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1883

8. AGE: Years 61 | Months 57 | Days 2 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER — 12. Name Peter Henry Mouse

13. Birthplace Md.

MOTHER — 14. Maiden Name Ella Kerns

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Rd

18 (a) Funeral director Edward Lonbaugh & Bro

(b) Address 2357 W. Pratt St. Baltimore, Md.

JUN 29 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27-44 1944 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1944, to 6-27 1944, and that I last saw him alive on 6-27 1944.

Immediate cause of death	Duration
Perforated duodenal Ulcer & Generalized Peritonitis	
Due to	
Due to	
Other Conditions Ulcers Chancres Tract. I Right Tumor (Include pregnancy within 3 months of death)	

Date of operation none

Major findings of operation:

of autopsy Perf. Duodenal Ulcer & Peritonitis

22. If death was due to external causes, fill in the following: 8/6

(a) Accident, suicide, or homicide Natural

(b) Date of occurrence June 27 1944 at M

(c) Where did injury occur? Baltimore Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? At Home While at work? No
(Specify type of place)

(e) Means of injury Fell on bed

23. Signature H. Bellis M.D. M. D.

Address Balt. City Hosp. Date signed

Approved: Robert Lee Graham M.D. 6/29/44

SUBJECT TO APPROVAL BY MEDICAL EXAMINER'S OFFICE.

PHYSICIAN

Underline the cause to which death should be charged statis-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 18540 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Community Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 W. Fairmont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Hubut MAYFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C.	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 22 1905

8. AGE: Years	Months	Days	If less than one day
99	0	6	.....hr. .....min.

9. Birthplace Atlanta Georgia
(Town, county, and state)
10. Usual Occupation Handy Man
11. Industry or business

FATHER
12. Name Willie Mayfield
13. Birthplace Georgia

MOTHER
14. Maiden Name Viles
15. Birthplace Georgia

16 (a) Informant Mary Mayfield
(b) Address 640 W Fairmont Ave

17 (a) Removal (b) Date thereof July 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Winston Salem N C
Location Forsyth County

18 (a) Funeral director Joseph A. Brely
(b) Address 1420 Mount Street

19 (a) JUN 29 1944 (b) [illegible] Williams M.D. Registrar
(Date rec'd by registrar)

VS 150 Approved Howard J. Walden M.D. per Robert Lee Graham M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28 19 44 at 10 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28 19 44 to 6-28 19 44 and that I last saw him alive on 6-28 19 44

Immediate cause of death	Duration
Cardiac Failure Probable	
Due to Cardio-Vascular Disease	
Due to Etiology Undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:.....
of autopsy: Emphysema - Left - Anterior

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature T. Mason Jones Jr. M. D.
Address..... Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGINS RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Couser ✓ G 18545

G-18545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Orchard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Couser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Della
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1920

8. AGE: Years 24 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Lynchburg, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Benjamin Council
15. Birthplace S. C.

MOTHER — 14. Maiden Name Lavinia Fuller
15. Birthplace S. C.

16 (a) Informant Della Council
(b) Address 502 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory Sumter
Location South Carolina

18 (a) Funeral director A. A. Halsted
(b) Address 918 Druid Hill Ave.

JUN 29 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1944 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24/44 to 6/27/44 and that I last saw h[illegible] alive on 6/27/44

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. C. Elser
Address [illegible] Date signed 6/28/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G 18542

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kozubek

3 (b) If veteran, name war

3 (c) Social Security Account No. 159-14-9664

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1883

8. AGE: Years	Months	Days	If less than one day
61	1	10	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Coal Miner & Laborer
11. Industry or business Beth Fairfield Co.,

FATHER
12. Name Lawrence Kozubek
13. Birthplace Poland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address " Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 40 S. Chester Street

19 (a) [illegible] Registrar
(b) [illegible]

JUN 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26- 1944, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1944 to 6-26 1944 and that I last saw h. alive on 6-26 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	5
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattman M.D.
Address B.C.H. Date signed 6/27/44

G 18543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 G 18543 Registered No. (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 MANHATTAN AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 MANHATTAN AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN ~~[illegible]~~ CHRISTINE SCHWABE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: ~~MARRIED~~ WIDOW

6 (b) Name of husband or wife: ~~WILLIS KING~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 11 1898

8. AGE: Years 46 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name AMEIL SCHIVABE
13. Birthplace NEW YORK

MOTHER
14. Maiden Name LOUISE ONNINGER
15. Birthplace GERMANY

16 (a) Informant ~~WILLIS KING (HUSBAND)~~
(b) Address 2806 MANHATTAN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-1744 (mo.) (day) (yr.)
(c) Cemetery or crematory ST. STANIALAUS
Location DUNDALK AVE.

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. WOLFE ST.

19 (a) (b) Registrar

JUN 29 1944
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JUNE 28 1944 at 11/30

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1943 to June 28 1944, and that I last saw h-r alive on JUNE 24 1944.

Immediate cause of death: Carcinoma Uterus with Metastases of
Due to: bladder + spine
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 14 mo 10 d

Date of operation August 6/43
Major findings of operation: cancer Cervix, Uterus + broad Ligament
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman R. Hart M.D.
Address 2601 Manhattan Av. Date signed 6/29/44

15

18544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

G 18544 Registered No.

RESERVED FOR BINDING MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 S. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 S Carey St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Michael F. Backoff

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-01-7012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence V. Backoff
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 1, 1881

8. AGE: Years	Months	Days	If less than one day
62 63	11	26	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)
10. Usual Occupation Guard
11. Industry or business Better Ice Cream Co

FATHER
12. Name Henry Backoff
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Alexander
15. Birthplace Baltimore Md

16 (a) Informant Mrs Florence V. Backoff
(b) Address 1410 S. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Memorial Pk
Location Dorsey Md.

18 (a) Funeral director John J Cowan & Son
(b) Address 90-03 Baltimore St

JUN 29 1944 (b) [illegible] Williams M.D.
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to June 27 1944 and that I last saw h alive on 19

Immediate cause of death Cerebral Hemorrhage — Duration 6 Mos.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Paul Schofield M. D.
Address 2301 Cermanwich Date signed 6/28/44

435510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G 18545
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 E. Biddle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Langhirt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 4-16-84

8. AGE: Years	Months	Days	If less than one day
60	2	11	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City of Baltimore

FATHER
12. Name Andrew Langhirt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Weigan
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave
18 (a) Funeral director John J. Cooney & Son
(b) Address 901 N. Eutaw St.
19 (a) JUN 29 1944 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 12 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to June 27 1944, and that I last saw him alive on June 27 1944

Immediate cause of death	Duration
Uremia	
Bacteremia - Staph hemol	
Due to Urinary Tract Tuberculosis - Staph.	
Due to Tuberculous prostate	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ronald B. Ross, M.D.
Address Johns Hopkins Hosp. Date signed 6/28/44

Huntington Williams, M.D.

12546 G 10546

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 472d

Registered No. 18 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 W. Lombard St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry E Sullivan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Catherine Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7th 1884

8. AGE: Years 60 | Months — | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Beth Ship Yard

FATHER
12. Name Eugene T. Sullivan
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sarah Worley
15. Birthplace Baltimore Md

16 (a) Informant Mrs Catherine Sullivan
(b) Address 1005 S. Boyd East

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan Son
(b) Address 2603 Pulaski St

19 JUN 29 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 1944, at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 19XX to June 28 19XX and that I last saw him alive on June 26 19XX.

Immediate cause of death Pulmonary Malignancy — Duration 6 mo's

Due to Metastasis — Duration 4 mo's

Due to — Duration —

Other Conditions — Duration —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave Date signed 6/28/44

G 18548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓183

Registered No. G 18548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Addison Rice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60+ | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name John Henry Perry

13. Birthplace Md.

MOTHER 14. Maiden Name Molly Perry

15. Birthplace Md

16 (a) Informant Addison Rice

(b) Address 912 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie A. Williams

(b) Address 322 N Schroeder St

JUN 29 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26-44 at 11.30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-26-44 at ? M.
(b) Where did injury occur? River, Dundalk, Md.
(c) Did injury occur at home, on farm, industrial place, in public place Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Walters M.D. Medical Examiner.
Date signed 6-26-44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18548

AB-16043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18548 Registered No. 46B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs-11mos. 30days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Richard Randolph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Martha (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8-1883

8. AGE: Years	Months	Days	If less than one day
60	6	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Tread Randolph
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUN 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 29 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25- 1944 at 2.30P

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 6/25 1944, and that I last saw h[illegible] alive on 6/25 1944

Immediate cause of death	Duration
Cardiac failure	
Due to A.S.C.V.D.; malig-	
Due to nancy of stomach (?) Coronary;	
Other Conditions Goiter, dyspnea;	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. L. Seigman M. D.
Address 19 C H Date signed 6/25

VS 180

F 1057

G 18529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 18529

PLACE OF DEATH:
(a) Baltimore City, Maryland Fallkner Bldg
(b) Street address Water and Bank Sts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 White Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Curran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1887

8. AGE: Years 57 | Months - | Days - | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Falconer Co

FATHER
12. Name James Curran
13. Birthplace Balto Md

MOTHER
14. Maiden Name Susan Burns
15. Birthplace Balto. Md.

16 (a) Informant Mary Curran
(b) Address 2915 White Ave

17 (a) Burial (b) Date thereof June 30-37
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loud. Balto
Location Old Frederick Rd

18 (a) Funeral director John A. McCann
(b) Address 3000 E. Balto. St.

19 (a) JUN 29 1937 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1937, at 1-05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage
due to hypertensive C.V. Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles J. Tubin M.D.
Medical Examiner.
Date signed 6/27/37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 18550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18550 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25-1880

8. AGE: Years	Months	Days	If less than one day
63	9	23	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Street Lighting Co

FATHER
12. Name Thomas Benj Scott
13. Birthplace Md

MOTHER
14. Maiden Name Sarah M. Hewitt
15. Birthplace Balto Md

16 (a) Informant Edna M. Scott
(b) Address 2930 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1-44 (month) (day) (year)
(c) Cemetery or crematory Dale Town
Location Eastern Ave. Bal.

18 (a) Funeral director John A. McGann
(b) Address 3002 E. Balto St

19 (a) JUN 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944 at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 29, 1944

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18551
Registered No.

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1472 Stevenson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-1
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1472 Stevenson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Greiner

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-2656 220-05-1673

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed.

6 (b) Name of husband or wife: Martin Greiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1869

8. AGE: Years 75 | Months — | Days 20 | If less than one day hr. min.

9. Birthplace Austria (Town, county and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Joseph Katz.
13. Birthplace Germany.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown.

16 (a) Informant Mr. John Greiner
(b) Address 1472 Stevenson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Annapolis Blvd. A.A.Co.

18 (a) Funeral director Chas. J. Dill
(b) Address 1511 E. Fort. Ave.

19 JUN 29 1944 (Date received by Registrar) Thurston Sta. Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1944, at 2:45 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13/1943 to 6/27/1944, and that I last saw her alive on 6/27/1944.

Immediate cause of death: Hypertensive cardio vascular disease.

Due to

Due to

Other Conditions - - -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M.D.
Address 1226 Hanover St. Date signed 6/29/1944.

18552
JL - 87970

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 518

G 18552
Registered No.

MARYLAND RESERVED FOR READING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -14
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1362 Towsen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ladislas Kodnow

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3410

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1881

8. AGE: Years	Months	Days	If less than one day
62	11	2	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Ladislas Kodnow
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Rose ?
15. Birthplace Czechoslovakia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 1st 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Brode Cem
Location R. A. Co Md.

18 (a) Funeral director Charles F. Dill.
(b) Address 1501 E. Fort ave.

JUN 29 1944 Huntington Williams, M.D.
(Date received) (Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28 1944 at 1a M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12 1944, to 6-28 1944, and that I last saw him alive on 6-28 1944.

Immediate cause of death	Duration
Carcinoma of Prostate	7
Due to with Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5-16-44
Major findings of operation: Carcinoma Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald A Hebb M. D.
Address Balto City Hosp Date signed 6-29-44

G 18553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G 18553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp 241
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 E Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Rossback

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-03-4884

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Rossbeck
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) 6/12/1917

8. AGE: Years 27 | Months | Days 17 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Stevedore

11. Industry or business

FATHER
12. Name: Philip Rossback
13. Birthplace: Russia

MOTHER
14. Maiden Name: Marie Siegler
15. Birthplace: Russia

16 (a) Informant: Catherine Rossback.
(b) Address: 1608 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3rd 1944 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross Cem.
Location: A. A. Co. Md.

18 (a) Funeral director: Charles F. Dill.
(b) Address: 1501 E. Fort Ave

19 (a) JUN 29 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 10.50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Depressed Fracture of skull

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 28 1944 24/1 20 8 P.M.
(b) Where did injury occur? Pier #9 Locust Point
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury: Pulley fell on head

23. Signature: Roland Lee Frateur M.D. Medical Examiner.
Date signed: June 29 1944

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. 44-18554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 N. Chapel St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Christopher

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age ~~71~~ 81 years

7. Birth date of deceased (mo., day, yr.) 7-15-~~82~~ 82

8. AGE: Years	Months	Days	If less than one day
62 ~~63~~	11	6	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Joseph Christopher
13. Birthplace Md

MOTHER
14. Maiden Name Josephine Gambol
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-1944 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Catonsville Md

18 (a) Funeral director Leo G. Losch
(b) Address 701-03 N. Patterson Park Ave

19 (a) JUN 29 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150 Duly 15

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944 at 8 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1944 to June 27 1944 and that I last saw he alive on June 27 1944

Immediate cause of death..... Coma — Duration yrs

Due to Cirrhosis of Liver
Ascites

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operations.....

of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Abraham Cohen

Address JHH Date signed 6-27

G 18555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160B

Registered No. G 18555

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted] hrs. 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Gleneagle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Janet Lee Reigle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/44

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Everett Clarence Reigle

13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Gladys Barnes

15. Birthplace Baltimore - Md.

16 (a) Informant Everett Reigle

(b) Address 3009 Gleneagle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location

18 (a) Funeral director J. J. Ruck

(b) Address 5305 Harford Rd

19 (a) JUN 29 1944 (Date rec'd by registrar) (b) Huntington & Williamsport, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28- 1944 to 6-29-1944 and that I last saw her alive on 6-28-1944.

Immediate cause of death: Intra-Cranial Hemorrhage — Duration

Due to: Prematurity (33-34) wks.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris Reese M. D.

Address 1016 Red Rd Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

Registered No. G 18556 or D-18556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Hollins St (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Kropf (KROPF)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-6344

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ethel Kropf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2-1882

8. AGE: Years 61 | Months 9 | Days 25 | If less than one day hr. min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Elevator Man

11. Industry or business Baltimore Engraving

FATHER 12. Name Henry Kropf
13. Birthplace Maryland

MOTHER 14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel Kropf
(b) Address 2115 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30-1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director George L. Lehnert
Frederick ave

JUN 30 1944

19 (a) (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 1944, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1944, to 6/27 1944, and that I last saw h[illegible] alive on 6/27 1944

Immediate cause of death Aortic Aneurysm — Duration 7

Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Carter M. D.

Address 2145 W Balto St Date signed 6/28/44

18552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. G 18552

MARGIN RESERVED. FILLED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Walbrook Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAISY R. CRIST

3 (b) If veteran, name war W. | 3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Charles Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1874

8. AGE: Years 69 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Vincent Spredden
13. Birthplace Baltimore

MOTHER
14. Maiden Name Smith
15. Birthplace Va.

16 (a) Informant Edwin E. Crist
(b) Address 2803 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore
18 (a) Funeral director Wm. Cook & Co.
(b) Address 1217 St. Paul St.

JUN 30 1944 (Date rec'd by registrar) Hamilton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944; at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7, 1944 to June 27, 1944 and that I last saw her alive on June 27, 1944

Immediate cause of death	Duration
Chronic Cholecystitis	5 yrs
Due to	
Due to	
Other Conditions: Arteriosclerosis ? Suspected Carcinoma 2 days	? ?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice E. Shamer M. D.
Address 3300 W. Mulberry Ave Date signed 6/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G 18538

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Elizabeth
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Westfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Malling

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace Denmark
(Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Danish Consulate
(b) Address

17 (a) Cremation (b) Date thereof June 30 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Federal Hill

18 (a) Funeral director Joseph Kaminskas Jr.
(b) Address 602 W. Washington Blvd

19 (a) Date received JUN 30 1944 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26-1944 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-19-44 at 2/3 P. M.
(b) Where did injury occur? City Harbor, Ft of Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Howard J. Rhoden M.D.
Medical Examiner.
Date signed 6-26-44

12555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 18553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARRIED FOR RECORDING RESERVED FOR

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 Garrison Blvd.
(c) Hospital or institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 St. Paul Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara S. Sturgeon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Harold M. Sturgeon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 6, 1866

8. AGE: Years 78 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Justus Stehl
13. Birthplace: Germany

MOTHER
14. Maiden Name: Fredericka Reuter
15. Birthplace: Md.

16 (a) Informant: Frieda S. Bond
(b) Address: 2719 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Greenmount
Location: Greenmount Ave. & Oliver St.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19. JUN 30 1944 (Date rec'd by registrar) (b) Huntington Mitchell M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 ~~19~~ to 6/29/44 19, and that I last saw her alive on June 28 1944.

Immediate cause of death — Duration

Nephritis, Chr. Interstitial — 6 mos.+

Due to: Hypertension

Myocardial Degeneration

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Hoffman, M. D. M. D.

Address 8 E. Read St. Date signed

G 13560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 458

Registered No. G 13560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Mrs. Wheeler's Nursing Home 1700 Park Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 Reservoir St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia A. Fenhagen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1864

8. AGE: Years	Months	Days	If less than one day
79	8	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name James C. Fenhagen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Cathell
15. Birthplace Baltimore, Md.

16 (a) Informant Charles C. Brownley
(b) Address 720 St. John's Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell's Sons, Inc.
(b) Address 1900 Eutaw Place

JUN 30 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1944 to 6/25 1944, and that I last saw her alive on 6/27 1944

Immediate cause of death Carcinoma of tongue — Duration 4 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Jones M. D.
Address 2818 St. Paul St. Date signed 6/30/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 18561
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Glen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced (married)

6 (b) Name of husband or wife Paul Rosen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Leo Fulce
13. Birthplace Russia

MOTHER: 14. Maiden Name Rose -
15. Birthplace Russia

16 (a) Informant Paul Rosen
(b) Address 3806 Glen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-44 (month) (day) (year)

(c) Cemetery or crematory Sinai Israel Cong
Location Smithern Ave

18 (a) Funeral director Poe Levin Bro
(b) Address E. Balto St. Baltimore, Md.

JUN 30 1944

19 (a) Huntington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to June 27 1944, and that I last saw her alive on June 29 1944.

Immediate cause of death: Cardio-respiratory failure — Duration: over 2

Due to: Bilateral Pleural Effusion

Due to: Metastatic Carcinoma

Other Conditions: Right hemiplegia, Cerebral edema — Duration: 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Damm M. D.
Address Sinai Hospital Date signed 6/29/44

VS 150

12562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G 12562
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Mont & Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elliott City (If outside city or town limits, write RURAL and give town)
(d) Street No. College Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachel ~~Ann~~ Elizabeth Pilson

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Wm H Pilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1860

8. AGE: Years 83 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Enoch D Thompson
13. Birthplace Md

MOTHER 14. Maiden Name Margaret J Carr
15. Birthplace Md.

16 (a) Informant Mrs. R.E. Erender
(b) Address 4011 Walbrook Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-44 (month) (day) (year)
(c) Cemetery or crematory Lutheran Chapel
Location Clarksville Md.

18 (a) Funeral director J.C. Higinbotham
(b) Address Ellicott City Md

JUN 30 1944

(b) [illegible] Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1944 at 7:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1944 to 6-29 1944 and that I last saw her alive on 6-29 1944.

Immediate cause of death Cerebral Embolism — Duration

Due to Mural Thrombi

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-28-44

Major findings of operation: Popliteal Embolism Rt.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.

Address St. Agnes Hosp Date signed 6-29-44

(OVER)

G 19563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G 19563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 46 E. 26th St.
(c) Hospital or institution:

12-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 46 E. 26th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RENA HAYWARD WATERS LEWIS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert Kendall Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1876

8. AGE: Years 68 | Months 3 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Kingston, Somerset Co., Md. (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business U. S. Internal Revenue

FATHER
12. Name John Thomas Waters
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Mary Acworth
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth L. Defandorf
(b) Address Alexandria, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery or crematory St. Andrew's Cem.
Location Princess Anne, Somerset Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 30 1944 (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1944, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1944 to 6/29 1944 and that I last saw h[illegible] alive on 6/28 1944

Immediate cause of death: Carcinoma of liver — Duration 6 mos.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature [signature] M. D.
Address 2818 [illegible] Date signed [illegible]

G 18564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 18564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is not known, please write the causes of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 Fleet ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester J Kazmierski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife Vera

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation ~~Watchman~~ Fireman

11. Industry or business Fairfield shipyard

FATHER
12. Name Michael Kazmierski
13. Birthplace Poland

MOTHER
14. Maiden Name Marcyanna Biskowska
15. Birthplace Poland

16 (a) Informant Vera Kazmierski
(b) Address 2029 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1-1944 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 JUN 30 1944 (b) [illegible], M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944, at 5 20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury June 28 1944 5 P.M.
(b) Where did injury occur? 2029 Fleet ST
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Fell off ladder

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed June 29 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write t

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 18664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4414 Raspe Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett Melvina Globensky

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: Wh
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Charles August
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1892

8. AGE: Years 51 Months 8 Days 28 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name L. Chard
13. Birthplace Unknown

MOTHER
14. Maiden Name Anna ?
15. Birthplace Unknown

16 (a) Informant Mrs. Alece F. Amyx
(b) Address 4414 Raspe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 1 - 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (Filed by registrar) JUN 30 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28/1944 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27/1944 to 6/28/1944 and that I last saw her alive on 6/28/1944.

Immediate cause of death	Duration
Congestive heart failure	
Due to Hypertensive heart disease	
Due to Chronic glomerulo-nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp. Date signed 6/28

324618 G 18566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 18566

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Pleasant Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-92

8. AGE: Years 51 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Elias Walker

13. Birthplace Md

MOTHER 14. Maiden Name Harriet Mobray

15. Birthplace Md.

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 1944 (month) (day) (year)

(c) Cemetery or crematory Breyer Hall

Location Annapolis Md

18 (a) Funeral director J. B. Johnson

(b) Address Annapolis Md

JUN 30 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 7 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1944 to June 29 1944, and that I last saw her alive on June 29 1944.

Immediate cause of death Uremia — Duration 4 wks.

Due to Hypertension and cardiovascular disease

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot V. Mowray

Address Johns Hopkins Hosp Date signed 6-30 44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.
Correct age is especially important.

10564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G 10567 9/a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 5/23/44 12
(e) Length of stay in Baltimore (yrs., mos., or days) Since 5/23/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County
(c) City or town Farmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MERRITT WILLIAM CARTNAL

3 (b) If veteran, name war	3 (c) Social Security Account No.
Peace time Veteran	215-12-2500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1908

8. AGE: Years	Months	Days	If less than one day
35	6	7	hr. min.

9. Birthplace Farmington, Iowa (Town, county, and state)
10. Usual Occupation 3rd Mate
11. Industry or business Merchant Marine

FATHER
12. Name Wm. Henry Cartnal
13. Birthplace Mo.

MOTHER
14. Maiden Name Cora ?
15. Birthplace Ill.

16 (a) Informant Records, U. S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 - 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Farmington, Iowa

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Road.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 30 1944

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH June 29, 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23, 1944, to June 29, 1944, and that I last saw him alive on June 29, 1944.

Immediate cause of death	Duration
Toxic myocarditis and bronchopneumonia	
Due to Subacute bacterial endocarditis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benjamin F. Jones
Address Baltimore, Md. Date signed 6/30/44

MS-53145

G 18503 ✓ G 18503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Redmond

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-20-1664

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1928

8. AGE: Years	Months	Days	If less than one day
16	5	25	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry W. Redmond
13. Birthplace Standardsville, Va

MOTHER
14. Maiden Name Louie Campbell
15. Birthplace Dunnsville, Va

16 (a) Informant Louie Redmond
(b) Address 1405 W. Lafayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Peter R. Kelly
(b) Address 322 N. Schroeder St

(a) JUN 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28- 1944, at 7.35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Lacerations of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-27-44 at Wilmington Del. M.
(b) Where did injury occur? Highway Delaware
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from truck - auto.

23. Signature Howard J. Claiborne M.D.
Medical Examiner.
Date signed 6-28-44

G 12568 ✓ G 12568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Harford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Barbara Ellis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	

6 (b) Name of husband or wife Rudolph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1902

8. AGE: Years	Months	Days	If less than one day: hr.	min.
41	9	7		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Work at Home

FATHER	12. Name Martin Gassmann
	13. Birthplace Baltimore Md.
MOTHER	14. Maiden Name Ida Wilke
	15. Birthplace Berlin Germany

16 (a) Informant Randolph W. Ellis
(b) Address 1037 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem Co
Location 3712 Edmondson Ave

18 (a) Funeral director Elmer W. Conkle
(b) Address 924 E. Eager St

19 (a) (b)
JUN 30 1944 Rec'd by registrar Registrar
VS 150 Hunter-Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/1944 at 12-05 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from 6/27/1944 to 6/29/1944 and that I last saw her alive on 6/28/1944.

Immediate cause of death	Duration
Circulatory Failure - Toxemia	
Due to Operation for Strangulated Ventral Hernia - Intestine	
Due to Gangrene	
Other Conditions Obesity	

(Include pregnancy within 3 months of death)
Date of operation 6/27/44
Major findings of operation Intestine Gangrene - Ventral Hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan E Colodny M.D.
Address St Joseph's Hospital Date signed 6/29/44

18570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G 18570

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Gray Russell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-25-1906.

8. AGE: Years	Months	Days	If less than one day
38	1	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Edward Gray
13. Birthplace Va.

MOTHER
14. Maiden Name Margret Sheridan
15. Birthplace Md

16 (a) Informant Rosa Upshur
(b) Address 1102 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) [illegible] for Williams M.D.

JUN 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 8-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944, to June 30 1944
and that I last saw h[illegible] alive on June 29 1944

Immediate cause of death Carcinoma of Liver — Duration

Due to Cirrhosis Uteri

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ? M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.
Address 1126 Monument [illegible] 6/30/44

G 12571 BALTIMORE CITY HEALTH DEPARTMENT G 12571

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 Wyman Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Wyman Park Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard M. Honemann

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophia M. Berry
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1860

8. AGE: Years 83 | Months 10 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Pensylvania R.R.

FATHER
12. Name Rudolf Honemann
13. Birthplace ## Holland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Mary Frances Russell
(b) Address 321 Wyman Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1738 Harford Avenue

JUN 30 1944 (Registrar) (b) ____ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to June 28, 1944 and that I last saw h~~e~~ alive on June 28, 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	
Cardio Vascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss, M.D.
Address 1927 E. North Ave. Date signed 6/29/44

G 13572 ✓ G 13572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 min
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Eager St. (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** William Morrison

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 231-03-9270

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lillie Morrison

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) aug 31 1906

8. AGE: Years 37 | Months 9 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Scotland Co. N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER 12. Name Melton E. Morrison

13. Birthplace N. C.

MOTHER 14. Maiden Name Millie Leach

15. Birthplace N. C.

16 (a) Informant Lillie Morrison

(b) Address 1010 Eager st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location .....

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly ave

JUN 30 1944 (Entered by registrar) Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 11:25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 29, 1944

VS 151

324294 C 18573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

C 18573 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State W. VA. (b) County
(c) City or town Martinsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Wilson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Glover

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ada Glover
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 10-11-95

8. AGE: Years 48 | Months 8 | Days 18 | If less than one day hr. min. 19

9. Birthplace W. VA. (Town, county, and state)

10. Usual Occupation watchmaker

11. Industry or business

FATHER
12. Name Urban Glover
13. Birthplace Ohio

MOTHER
14. Maiden Name Sarah Odell
15. Birthplace PA

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 3/44 (month) (day) (year)
(c) Cemetery or crematory WOOD LAWN
Location WOOD LAWN MD.

18 (a) Funeral director Lilly and Beeler Inc.
(b) Address 403 [illegible] Williams, MD

JUN 30 1944 (b) Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at 4 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944 to June 30 1944 and that I last saw h[illegible] alive on June 30 1944.

	Duration
Immediate cause of death acute pulmonary edema	
Due to Cardiac failure	
Due to Arteriosclerotic heart disease	8 yr.
Other Conditions Carcinoma of sigmoid colon	1 yr.

(Include pregnancy within 3 months of death)

Date of operation June 27, 1944
Major findings of operation: Cancer of sigmoid. Wide spread metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L. Kayser
Address J. H. Hos. Date signed 6/30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

32452 18574 G 18574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 S. Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Lewis

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-40

8. AGE: Years 3 | Months 8 | Days 17 | If less than one day: hr. min.

9. Birthplace BALTIMORE Md
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Andrew J. Lewis
13. Birthplace (Va)

MOTHER
14. Maiden Name Helen Brown
15. Birthplace BALTIMORE (Md)

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof JULY 3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Gerlach
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

JUN 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29-1944 at 11:29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20-1944 to 6-29-1944 and that I last saw h[illegible] alive on 6-29-1944.

Immediate cause of death: Peritonitis, General — Duration: 2 days
Due to: Ruptured pelvic abscess — 7
Due to: Appendicitis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 6/20/44
Major findings of operation: Acute appendicitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugo V. Ciriglio
Address Hugo V. Ciriglio Johns Hopkins Hosp. M. D.
Date signed 6-29-44

G 10575 ✓ G 10572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. ____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 S.EATON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 S.EATON ST.
(If rural give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3 (a) FULL NAME ROBERT H.SAUTER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 215 10 5848

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MADALINE E.SAUTER
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) MAY 31 1906

8. AGE: Years 38 | Months 0 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation FOREMAN
11. Industry or business DAVIDSON CHEMICAL CO.

FATHER
12. Name CHARLES SAUTER
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name MATILDA BIGEREOW
15. Birthplace BALTO.MD.

16 (a) Informant MADALINE SAUTER(WIFE)
(b) Address 903 S.EATON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 1/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Butler INC.
(b) Address 403 S.WOLFE ST.

(a) Date rec'd by regis(trar) JUN 30 1944 (b) ____ by Registrar

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JUNE 27 1944 at 4/30M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1944 to 6/27 1944, and that I last saw h last alive on 6/27 1944

Immediate cause of death	Duration
t Pneumonia	
Due to Influenza	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(e) Means of injury ____
23. Signature J. J. Carroll M. D.
Address 933 S. Conkling Date signed 6/29/44

Funeral Director Wilmington, N.C.

18576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1576 Registered No. G 19526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 295 West 31st St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 295 W. 31st St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doris May Shugars

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1944

8. AGE: Years	Months	Days	If less than one day
	1	23	hr. min.

9. Birthplace Doctors Hospital: Washington D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Leesburg Va

MOTHER / FATHER

12. Name Edgar Monroe Shugars

13. Birthplace Leesburg Va

MOTHER

14. Maiden Name Theresa Marie Nickell

15. Birthplace Baltimore Md

16 (a) Informant Parents

(b) Address 295 W. 31st St

17 (a) Removal (b) Date thereof June 30-44 (Burial, cremation, or removal) (month) (day) (year)

Burial

(c) Cemetery or crematory St Mary's

Location Hampden

18 (a) Funeral director Demarchi & Donovan

(b) Address 613-17 Chestnut ave

19 (a) June 30 1944 Date received by registrar Walter H. Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at ? M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5th 1944, to June 27 1944, and that I last saw her alive on June 27 1944.

Immediate cause of death	Duration
Collapse, Ruptured Meningocele	
Due to Skull Bifida	
Dorsal - Lumbar region	
Due to	
Other Conditions Paralysis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Lyman Kittle M. D.

Address 229 W. Date signed

Calvert St

G 12577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G 12577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Burkhead

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27, 1939

8. AGE: Years	Months	Days	If less than one day
5	1	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Frederick H. Burkhead
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine F. Thompson
15. Birthplace Virginia

16 (a) Informant Frederick H. Burkhead
(b) Address 1846 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Pole
(b) Address 1200 N. Longwood St.

JUN 30 1944 (Date rec'd by registrar) (b) Burial Permit Issued Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30- 19 44 at 6 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Peritonitis
Due to
Other Conditions Ruptured Appendix; Severe hypotonic uterine contractions
(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-10-44 at 8/2 5 P. M.
(b) Where did injury occur? 1200 N. Gay St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Slipped, climbing on wrong side of bed.

23. Signature Howard J. Claggett M.D. Medical Examiner.
Date signed 6-30-44

G 13578 ✓ G 13572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. Gen. Hosp.
(c) Hospital or institution: Isolation & Pediatrics 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 2 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? Lyndhurst St. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lyburn "John Lyburn"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-28-44

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John T. Lyburn
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Marian Inez Stembridge
15. Birthplace Va.

16 (a) Informant Mrs. Emma Lyburn
(b) Address 302 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June-30-44 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 505 N. Monroe St.

JUN 30 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 5-00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to June 30 1944, and that I last saw him alive on June 30 1944.

Immediate cause of death Prematurity — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas A. Mitchell M. D.

Address Md. Gen. Hosp. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G 13579 ✓ G 13579

CERTIFICATE OF DEATH 946

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4501 Springdale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 Springdale Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Emma V. Hubbard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm. Henry Hubbard
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1880

8. AGE: Years	Months	Days	If less than one day
63	8	22	--hr. ---min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Wm. Charles Gumpman
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Augusta Gore
15. Birthplace Germany

16 (a) Informant Harold H. Hubbard
(b) Address Randallstown, Md.

17 (a) Burial (b) Date thereof 7/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodland, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

JUN 30 1944 (Date rec'd by registrar) Lentz for Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1944, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to June 1944, and that I last saw her alive on 6/25 1944.

Immediate cause of death ..... Duration
Angina Pectoris 1yr.
Due to Arteriosclerosis
Due to .....
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature E. J. Wenick M.D.
Address 4710 Liberty Rd Date signed 6/29/44

G 13580 ✓ G 13580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 364
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Asquith St. Balt, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry P. Kreis.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Geraldine Kreis.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1900

8. AGE: Years	Months	Days	If less than one day
43 44	109	15	hr. min.

9. Birthplace Baltimore Maryland
(Town, county and state)
10. Usual Occupation Tire Salesman
11. Industry or business Tire

FATHER
12. Name Henry P. Kreis Sr.
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Lawrence.
15. Birthplace Unknown.

16 (a) Informant Mrs Geraldine Kreis.
(b) Address 2621 Asquith St. Balt. Md.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Herman & Son
(b) Address 805 W. Colvert St.

JUN 30 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 at 7.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1944 to June 29 1944 and that I last saw him alive on June 29 1944

Immediate cause of death Resp. Failure — Duration 29 hrs.

Due to Cerebro Vasc. accident — 11 mos.

Due to Hypertension. — 2 yrs (?)

Other Conditions Malignant

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. R. Ziegler
Address Mercy Hosp. Date signed 6/29/44
M. D.

G 18581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 18581 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Southway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Grant Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Donahue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1878

8. AGE: Years	Months	Days	If less than one day
65	11	27	hr. min.

9. Birthplace Philadelphia (Town, county, and state)
10. Usual Occupation Trust Officer
11. Industry or business Maryland Trust Co.

FATHER
12. Name James B. Thomas
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Lizzie Grant
15. Birthplace Pennsylvania

16 (a) Informant Mrs. George Grant Thomas
(b) Address 407 Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery or crematory Brandywine Manor
Location Chester Co., Pa.

18 (a) Funeral director Thompson & Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Hamilton Wilmington M.D.

JUN 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7/1944 to 6/29/1944, and that I last saw him alive on June 29, 1944.

Immediate cause of death	Duration
Arteriosclerosis	
Due to	
Due to	
Other Conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J R Miller M. D.
Address Date signed June 30 1944

C 18582 BALTIMORE CITY HEALTH DEPARTMENT Ahearn C 18582

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5410 Mayview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5410 Mayview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine A. Ahearn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Cornelius F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1872

8. AGE: Years 71. | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Brooklyn NY (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Patrick Dobbins
13. Birthplace NY

MOTHER
14. Maiden Name Hannah Riordan
15. Birthplace Ireland

16 (a) Informant Mrs John E Spencer
(b) Address 5410 Mayview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1944 (month) (day) (year)
(c) Cemetery or crematory St Johns Cem
Location Middle Village L.I. NY

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) (Date received by registrar) (b) Registrar

JUN 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 5-45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to June 30 1944, and that I last saw deceased alive on June 30 1944.

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertension
Due to Myocardiosclerosis
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Thornfeld, M.D.
Address 540 V Belair Rd Date signed June 30 1944

G 19583 ✓ G 19583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Woods

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-28-44

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Francis Woods
13. Birthplace Baltimore Md

MOTHER: 14. Maiden Name Mary C Deal
15. Birthplace Baltimore Md

16 (a) Informant Francis W. Woods
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director John C Mozan
(b) Address 3000 E Baltimore

JUN 30 1944 Huntington Williams (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 44 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28 1944, to 6-30 1944, and that I last saw him alive on 6-30 1944.

Immediate cause of death Congenital Heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan C Chesin M. D.
Address St Josephs Hospital Date signed 6/30, 44

G 12524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 12524

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NAMES RESERVED FOR INDEXING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Grace Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John H. Sherman

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): 3-17-1892

8. AGE: Years: 52 | Months: 3 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER — 12. Name: William H. Abrahams

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden Name: Margaret Warnyter

15. Birthplace: Baltimore, Md.

16 (a) Informant: JOHN A. SHERMAN

(b) Address: 2800 GUILFORD AVE

17 (a) Burial (Burial, cremation or removal) (b) Date thereof: 7/1/44 (month) (day) (year)

(c) Cemetery or crematory: GREENMOUNT

Location

18 (a) Funeral director: Chas. J. Evans & Son Inc.

(b) Address: 118 N. Mt. Royal Ave

19 (a) (Date received by registrar) (b) Registrar

JUN 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1944, at 10:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944, to June 28 1944, and that I last saw h[illegible] alive on June 28 1944.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to: Cerebral Hemorrhage	
Due to: Hypertension Cardio-Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Stephen Van Petten M. D.

Address: Union Memorial Hosp. Date signed: 6-28-44

(over)

G 19525 ✓ G 19525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Ross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Ross St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josepine A Scally

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Cockeysville Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Patrick Scally
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Cummings
15. Birthplace Ireland

16 (a) Informant Mrs M. Brooks Scally
(b) Address 5422 Belair Rd

17 (a) Burial (b) Date thereof 7/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Joseph Cem
Location Md

18 (a) Funeral director Mary M. Dougherty
(b) Address 50 E Preston St Baltimore, Md.
JUN 30 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944, at 10 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1943 to June 28 1944, and that I last saw her alive on June 28 1944

Immediate cause of death	Duration
Due to Hypertrophy Cirrhosis of Liver	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E F a Stevens M. D.
Address 2878 Harford Rd Date signed 6/29/44

MARYLAND RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-68342

Registered No. 935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs-8mos-1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Violet Crow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- 1846

8. AGE: Years 98 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Dailey
13. Birthplace Ireland

MOTHER
14. Maiden Name Marie ?
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Garrison Hill Rd

18 (a) Funeral director J. J. Feaby & Sons
(b) Address 1314 Light St

19 (a) Date received by local registrar July 1 1944 (b) Huntingtown Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1944, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 6/22 1944, and that I last saw h[illegible] alive on 6/22 1944.

Immediate cause of death: Cardiac failure — Duration

Due to A.S.C.V.D

Due to

Other Conditions Hem. arteriosclerosis; and emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.

Address BCH Date signed 6/26

G 12507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G 12507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Wirton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Wirton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Collins Henschke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Rose Cecilia Henschke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19th 1886

8. AGE: Years	Months	Days	If less than one day
58	0	10	hr. min.

9. Birthplace York Pa
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business C-P Telephone Co.

FATHER
12. Name Wm F. Henschke
13. Birthplace Pa.

MOTHER
14. Maiden Name Mollie A. Willhide
15. Birthplace Md.

16 (a) Informant Wm D. Henschke
(b) Address 1304 Wirton St

17 (a) Burial (b) Date thereof July 3rd 1944
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St

19 Date received by registrar JUL 1 1944 (Signature) Williams Myth Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29th 1944 at 12 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5-1944, to 6-29-1944, and that I last saw h~~im~~ alive on 6-28-1944.

Immediate cause of death	Duration
Chronic cardio vascular disease	Unknown
Due to Uremia	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fro. B. Sylvest M. D.
Address 780 V Harford Rd Date signed 6-30-44

18588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 18588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2741 Tivoly Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 Tivoly Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John B. Sanner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~:
Male	White	Married

6 (b) Name of ~~husband or~~ wife Rose A. Sanner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3rd 1882

8. AGE: Years	Months	Days	If less than one day
62	4	26	hr. min.

9. Birthplace Conn
(Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Balto. City

FATHER
12. Name Johnathan Sanner
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Rose A. Sanner
(b) Address 2741 Tivoly Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof July 3rd 1944 (month) (day) (year)
(c) Cemetery ~~crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUL 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29th 1944, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6-1943, to 6-29-1944, and that I last saw him alive on 6-28-1944.

Immediate cause of death	Duration
Coronary occlusion	6 mos.
Due to	
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo B. Dyhert M. D.
Address 2802 Harford Rd Date signed 6-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 12583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G 12583

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D o a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosaria Fertitta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband ~~or wife~~: VINCENT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 4- 1868

8. AGE: Years 76 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace ITALY (town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name SALVATORE MICCICHE
13. Birthplace ITALY

MOTHER
14. Maiden Name FRANCES TESTA
15. Birthplace ITALY

16 (a) Informant ROBERT FERTITTA
(b) Address 5003 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director Wm Cook Jno.
(b) Address 1217 St Paul St

19 (a) JUL 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D. Medical Examiner.
Date signed June 30 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 19596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Leslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "A." PACURAR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-44

8. AGE: Years | Months | Days | If less than one day: 16 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ~~Leslie~~ Arnold PACURAR
13. Birthplace

MOTHER 14. Maiden Name Linda
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUN 30 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 1 1944 (Date received by Registrar) Huntington Williams M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944, to June 27 1944, and that I last saw him alive on June 27 1944.

Immediate cause of death	Duration
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Waugh M. D.
Address J.H.H. Date signed 6-27-44

F 1065

G 19591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 19591 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Leslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy "B" PACURAR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26-44

8. AGE: Years | Months | Days | If less than one day: 16 hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arnold PACURAR
13. Birthplace

MOTHER 14. Maiden Name LINDA
15. Birthplace

16 (a) Informant R
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUN 30 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 1 1944 (Date rec'd by Local Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944, to June 27 1944, and that I last saw him alive on June 27 1944.

Immediate cause of death	Duration
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Warner Jr. M. D.
Address U.H.H. Date signed 6/27/44

F 1064

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

Registered No. G 18598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital 10 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 10days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Brenda Cecilia Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15, 1944

8. AGE: Years | Months | Days: 10 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name William Woods
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Allen
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL JUN 30 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) OCT 1 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1944, at 10.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1944, to June 23 1944, and that I last saw her alive on June 23 1944.

Immediate cause of death Subarachnoid hemorrhage; Pulmonary hemorrhage — Duration .....

Due to Heat stroke — Duration .....

Due to Heat therapy — Duration .....

Other Conditions — Duration .....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Philip P. Stapleton, Jr. M. D.
Address Johns Hopkins Hospital Date signed 6-27-44

1063

19526

JL - 88620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133a

Registered No. G 19526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.,

(c) Hospital or institution: Baltimore City Hospitals 5-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1120 May St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ola Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1889 ?

8. AGE: Years 55 ? Months 2 ? Days 17 ? If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lawrence Cook

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name Sara Henderson

MOTHER 15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery

Location Edwin O Wedson

18 (a) Funeral director Brantley & Co

(b) Address 16

19 JUL 1 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 1944, at 5 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1944 to 6/27 1944 and that I last saw h alive on 6/27 1944

Immediate cause of death: Hypostatic pneumonia

Due to: Pyelonephritis

Due to: Cardiac failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration
?
?
?
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattma

Address B. C. H. Date signed 6/30/44

VS 160

G 19524

JY - 73117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 19524

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 - 2- 22
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1723 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Elijah Winston

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1926

8. AGE: Years: 17 | Months: 8 9 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)
10. Usual Occupation: School
11. Industry or business:

FATHER
12. Name: Robert Winston
13. Birthplace: Va.

MOTHER
14. Maiden Name: Emma Carter
15. Birthplace: Va.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial, cremation, or removal: Burial (b) Date thereof (month) (day) (year): Aug 2nd/44
(c) Cemetery or crematory: Mt Calvery
Location:

18 (a) Funeral director: Elroy O Wilson
(b) Address: 1000 Brantley Huntington Williams, W.Va.

19 (a) Date rec'd by local registrar: JUL 1 - 1944 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1944, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1944 to 6/29 1944, and that I last saw h[illegible] alive on 6/29 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 2 yrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Paul Hesbma
Address: B.C.H. Date signed: 6/30/44 W.D.

G 19535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 19535 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2556 Hollins St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2556 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie J. Woodland

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm C. Woodland

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 10-1872

8. AGE: Years 71 | Months 8 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Summerfield Meekins
13. Birthplace Md

MOTHER 14. Maiden Name Margaret Daniels
15. Birthplace Md

16 (a) Informant Jennie V. Woodland
(b) Address 2556 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. P. Shipperd & Son
(b) Address 850 N. Eutaw St.

19 (a) ..... (Date rec'd by registrar) (b) Harry J. Williams, M.D. Registrar

JUL 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29th 1944, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 6/29 1944, and that I last saw h[illegible] alive on 6/29 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 6 days
Due to Arterial Sclerosis
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Chas A Corbin M. D.
Address 2145 W Balto St Date signed

G 19536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121

Registered No. G 19536

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette. Cor Howard Sts
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 12-6
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Edna N. Ramsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 17th 1892

8. AGE: Years 54 | Months 1 | Days 13 | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John A. Ramsey
13. Birthplace Maryland

MOTHER
14. Maiden Name Hedwig G. Pyle
15. Birthplace Maryland

16 (a) Informant Mrs. Hedwig G. Ramsey
(b) Address 2735 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5th 44 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location Delroy Pa.

18 (a) Funeral director F. D. Heugel Inc
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) JUL 1 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1944, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1944, to 6-30 1944, and that I last saw h[illegible] alive on 6-27 1944

Immediate cause of death: Pulmonary Embolism

Due to

Due to

Other Conditions Operated on 5-27-44 (Include pregnancy within 3 months of death)

Date of operation 5-27-44

Major findings of operation: Appendicitis Gangrenous Perforation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel, Jr. M. D.
Address Bon Secours Hosp Date signed 6-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BLANKS RESERVED FOR RUBBER STAMPING

G 19592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G 19592 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilken Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4312 Leeds Ave. 29 (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Thos. Thelma Fitzgerald

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Norman N. Fitzgerald
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1910

8. AGE: Years 33 | Months 6 | Days 12 13 | If less than one day ... hr. ... min.

9. Birthplace Md. - Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Williams Baynes
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Maryland

16 (a) Informant T. Loftus
(b) Address St Agnes Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location city

18 (a) Funeral director Mr-Mrs. John W. Teufel-Son
(b) Address 801 W. Fayette St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

JUL 1 1950 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944, to June 30 1944; and that I last saw h[illegible] alive on June 29 1944.

Immediate cause of death: Chronic Rheumatic endocarditis with mitral insufficiency — Duration

Due to ...

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. Arthur Loftus

Address St. Agnes Hosp. Date signed 6/30/44

G [illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Arlington Park Apts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-30
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6701 Park Heights ave Arlington Park Apts. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME DELIA LOUCHHEIM HAMBURGER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel I. Hamburger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1866

8. AGE: Years 77 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Adolf Louchheim,
13. Birthplace Germany.

MOTHER
14. Maiden Name Lissette Arnold,
15. Birthplace Hagerstown, Md.

16 (a) Informant Mr. Adolf Hamburger,
(b) Address Arlington Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/44. (month) (day) (year)
(c) Cemetery Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director David Lowenstein's Son
(b) Address 1902 Eutaw Place.

19 (a) JUL 1-1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29th. 1944, at 12.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1936 to June 29 1944. and that I last saw h[illegible] alive on June 29 1944.

	Duration
Immediate cause of death Arteriosclerotic heart disease Symptoms	9 mos.
Due to Coronary artery sclerosis	9 mos.
Due to Generalized arteriosclerosis Symptoms + signs	8 years
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place. Date signed

G 12559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G 12559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Emersonian Apts.
(c) Hospital or institution: 13+1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Emersonian Apts. (If rural give location) Eutaw Place & Park Drive
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ELLA PUTZEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Arthur Putzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1871.

8. AGE: Years	Months	Days	If less than one day
72	7	0 24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Slesinger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Ellen Prag,
15. Birthplace Balto. Md.

16 (a) Informant Mr. Arthur Putzel,
(b) Address Emersonian Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7.2.44. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Har Sinai
Location Balto. Md.

18 (a) Funeral director Harris Levin & Levin
(b) Address 1902 Eutaw Place.

19 JUL 1-1944 (b) Hunting for Williams, M.D.
(Date rec'd by registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th. 1944 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1919 to June 29, 1944 and that I last saw h e alive on 6/29/44 1944.

Immediate cause of death Coronary Thrombosis — Duration about 12 hrs.
Due to
Due to
Other Conditions Arteria Sclerosis Hypertension — Abt 5 yrs.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore H. Morrison M. D.
Address ~~Temple Garden Apts.~~ 11 E. Chase St. Date signed 6/30/44

G 19600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 19600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure to give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3442 Kenwick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3442 Kenwick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilly Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife Harry L Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16, 1867

8. AGE: Years	Months	Days	If less than one day
77	2	13	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Joseph Spellman.
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Harry L. Clark Jr.
(b) Address 3442 Kenwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 1944 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden

18 (a) Funeral director L Emmett & Donaro
(b) Address 3610-12 Sebastian Ave

19 JUL 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 at 8 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester P. Fulmer M.D. Medical Examiner.
Date signed 6/27/1945

VS 151

20688621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G 19621 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 960 Franklin Town Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Stencel

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Blanche Stencel
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 2-28-79

8. AGE: Years	Months	Days	If less than one day
65	4	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business Chas. T. Brandt, Inc.

FATHER
12. Name Joseph Stencel
13. Birthplace Bad Germany

MOTHER
14. Maiden Name Martha ?
15. Birthplace ~~Bad~~ Germany

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to June 29 1944 and that I last saw him alive on June 29 1944.

Immediate cause of death	Duration
Due to Pulmonary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cenecin M. D.
Address 704 Date signed 6-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Hunter Williams, M.D.

G 19602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

G 19602 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR B...ING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 N. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 1 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Harry J Wood
13. Birthplace Balto. Md

MOTHER — 14. Maiden Name Dorothy P.
15. Birthplace Balto. Md.

16 (a) Informant Hospital Records
(b) Address St. Joseph's

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director J. Lafayette Neal
(b) Address 2601-03 E. Madison St

19 (a) JUL 1 - 1944 (Date rec'd by registrar) Timothy Jos. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944, to 6-29 1944, and that I last saw h... alive on 6-29-44 19

Immediate cause of death Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan E Cohodas M.D.
Address St Joseph's Hosp Date signed 6/30/44

MARG... RESERVED FOR B...ING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1616

Registered No. G 18603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 770 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bobby Boe Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/29/44 3:30 P.M.

8. AGE: Years | Months | Days | If less than one day: 19 hr. [illegible] min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name J. L. Brooks.
13. Birthplace Dalton, Georgia

MOTHER
14. Maiden Name Lillie May Callahan
15. Birthplace Dalton, Georgia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 1 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30/44 19 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29-1944 to 6-30-1944 and that I last saw h[illegible] alive on 6-30-44 4 P

Immediate cause of death	Duration
Acute Pulmonary Edema.	19 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 576 Lexington Blvd Date signed 6/30/44

VS 150

1066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

√46 B G [illegible]

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Dolphin St., Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Mrs Mamie Wilkerson

If U. S. Veteran specify WAR .....

(a) Residence: No. 616 Dolphin St., Ward 17-2

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Col	W

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert

6. DATE OF BIRTH (month, day, year) 3/12/1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	3	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Henry Diggs

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Annie Gibson

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Betty Wilkerson

(Address) 616 Dolphin St. Balto. Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Auburn Date 7/3/44 19..

19. UNDERTAKER George E. Folson

(Address) 1303 Freeman St.

20. FILED ..... 19.. Registrar

JUL 1 - 1944

MEDICAL CERTIFICATE OF DEATH

31. DATE OF DEATH (month, day, year) June 30, 1944

22. I HEREBY CERTIFY, That I attended deceased from March 20 1944 to June 20, 1944

I last saw h[illegible] alive on June 30 1944 Death is said to have occurred on the date stated above, at 8 a. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma Stomach	
	?
Other contributory causes of importance:	

Was an operation performed? ... Date of ...

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify .....

(Signed) Edward J. Wheatley M. D.

(Address) 1730 Druid Hill Ave

N. B.—WRITE PLAINLY. ALL ENTRIES MUST BE MADE IN INK. THIS information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements OCCUPATION is very important. See instructions on back of certificate.

G 13605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13605 / 112 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARG... RESERVED FOR B...ING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1687 Darley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1687 Darley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William R Siebert

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-03-3027

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Siebert
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Apr 16 - 1885

8. AGE: Years 59 | Months 2 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Furniture

FATHER
12. Name Wm A Siebert
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant LeRoy Siebert
(b) Address 1687 Darley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/44 (month) (day) (year)
(c) Cemetery or crematory Balto Cemetery
Location Balto Md

18 (a) Funeral director Wm. Ulmer Funeral Home
(b) Address 208 Orleans St

19 (a) ... (Date rec'd by registrar) (b) Hunter for Williams, M.D.

JUL 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 9 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1936 to June 30 1944 and that I last saw him alive on June 29 1944.

Immediate cause of death: Cardiac Decompensation — Duration 2 wks
Due to Bronchial Asthma — 10 yrs +
Due to ...
Other Conditions Emphysema — 10 yrs +
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — — — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Vincent V. Jooka, M.D.
Address 845 N. Patterson Park Ave Date signed 7/1/44

G 18006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 18006 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geo Biddison

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 1885
8. AGE: Years 58 | Months 9 | Days | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Produce dealer
11. Industry or business

FATHER
12. Name Geo. H. Biddison
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Fink
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Kathrine Engelhardt
(b) Address 3040 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Pennsylvania Ave, Baltimore, Md

19 (a) JUL 1 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30-1944, at 7:30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Chronic Nephritis; Bronchitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 6-30-44

3246647 G 18627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18627 108.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Dundalk. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6516 Baltimore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carl E. Benton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Frances Benton

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 3-24-08

8. AGE: Years 36 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Electric Welder

11. Industry or business

FATHER
12. Name Richard Benton
13. Birthplace N.C.

MOTHER
14. Maiden Name Lizzie Green
15. Birthplace N.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/44 (month) (day) (year)
(c) Cemetery or crematory Parkview Church M.E.
Location Suffolk Va.

18 (a) Funeral director Colvin Quintchell Sons
(b) Address 1 Centaur Place

19 (a) JUL 1-1944 (Date received by registrar) (b) Huntington W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at 12 17 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to June 30 1944 and that I last saw him alive on June 30 1944.

Immediate cause of death ____ Duration

Due to Lobar pneumonia, RUL, RML, RLL, LLL due

Due to Type 4 pneumococcus

Other Conditions Alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place; in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chelsea Greene M.D.
Address 300 Date signed 6-30

G 15638 — BALTIMORE CITY HEALTH DEPARTMENT — G 15638 — Registered No. 1041

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 N. Greene Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Sue Marcum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1944

8. AGE: Years | Months: 65 | Days: 29 | If less than one day: hr. min.

9. Birthplace Ashland, Ky. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William M. Marcum
13. Birthplace Lafolette, Tenn.

MOTHER — 14. Maiden Name Arminta Morrison
15. Birthplace Ashland, Ky.

16 (a) Informant William H. Marcum
(b) Address 308 N. Greene Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lafolette Tenn.
Location Tenn.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (Date rec'd by local registrar) 7-1-1944 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1944, at 10:40 A. M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremic Poisoning, Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D. Medical Examiner.
Date signed July 6 1944.

VS 151

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 19638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Arabia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RACHEL E. KEYS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George T. Keys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1867

8. AGE: Years 77 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace White Hall, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Sipes
15. Birthplace Md.

16 (a) Informant Mrs. Eva Keys McCall
(b) Address 4614 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

JUL 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH June 30, 1944, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 30 1944 and that I last saw her alive on June 29 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 days

Due to: Cerebral Arteriosclerosis — Duration indeterminate

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Sawyer, M.D.

Address 4808 Harford Rd. Date signed 6/30/44

Quintella

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. G 13610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired for and every item should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 Albemarle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Earl A. Quintella

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 4/12/44
8. AGE: Years | Months 2 | Days 18 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Anthony Quintella
13. Birthplace Cuba

MOTHER
14. Maiden Name Florence Moulstale
15. Birthplace Md

16 (a) Informant Anthony Quintella
(b) Address 42 Albemarle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore
18 (a) Funeral director Bela Windefeld
(b) Address 914 Gunmount Ave
19 JUL 1 - 1944 (b) (Date rec'd by Registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30- 19 44 at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymico-lymphaticus

Due to

Other Conditions Partial atelectasis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mendeno M.D. (Medical Examiner.)
Date signed 6-30-44

G 19611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 19611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Woodlea Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Woodlea ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward J. Schneider
3 (b) If veteran, name war No
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary Schneider
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 30th 1892

8. AGE: Years	Months	Days	If less than one day
51	11	—	hr. min.

9. Birthplace Balto Co. Md. (Town, county, and state)
10. Usual Occupation Rate Clerk
11. Industry or business B. & O. R. R.
12. FATHER Name Fred. Schneider
13. Birthplace Germany
14. MOTHER Maiden Name Agnes A. Kuntz
15. Birthplace Balto. Co. Md.
16 (a) Informant Mrs. A. L. Schneider
(b) Address 4010 Woodlea Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto. Co. Md.
18 (a) Funeral director Casper Funeral Home
(b) Address 7401 Belair Road
19 Filed July 1 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1944, at 12 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944 to June 30 1944, and that I last saw him alive on June 30 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to Rheumatism	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 6-30-44

VS 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G 13612

G 13612

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 969 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 969 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1918

8. AGE: Years 25 26 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Woodward, S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Frank Code
13. Birthplace S. C.
14. Maiden Name Beatha Stewart
15. Birthplace S. C.

16 (a) Informant Frank Code Jr.
(b) Address 969 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/44 (month) (day) (year)

(c) Cemetery or crematory Bethel
Location Woodward S. C.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley Ave

19 (a) Date received (Registrar) Wentworth Williams, M.D.

JUL 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 29 1944, at 6.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 1 1944 to JUNE 29 1944 and that I last saw h-er alive on JUNE 29 1944.

Immediate cause of death CANCER OF UTERUS — Duration 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry N. Rosenthal M. D.
Address 1902 Eutaw Pl. Date signed 7-1-44

19643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 19643

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and answered. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Frankford Ave
(c) Hospital or institution:

26-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Frankford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John George Weiler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1867

8. AGE: Years	Months	Days	If less than one day
76	7	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John G. Weiler
13. Birthplace Balto

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

JUL 1-1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944, to June 29 1944, and that I last saw h[illegible] alive on June 28 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Myocardial Insufficiency	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Schmunk M. D.
Address 1337 S. Charles St Signed 7/1/44

G 18614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G 18614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Harrison ave. (Rooms)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Faustman

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-2604

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Virginia Faustman
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1912

8. AGE: Years 31 | Months 7 | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Pikesville Md.
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Wm F. Faustman
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Anna Handy
15. Birthplace Balto. Md

16 (a) Informant William F. Faustman
(b) Address 824 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Loring Byers
(b) Address 5005 Liberty Heights Ave.

19 (a) Date received by Registrar JUL 1 1944 Huntting Sr. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30- 1944, at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-30-44 at A M.
(b) Where did injury occur? 2807 Harrison ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suspended by rope around neck

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 6-30-44

G 18615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

62 Registered No. G18615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elijah Johnson

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 22nd 1911

8. AGE: Years 33 | Months 1 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Norfolk Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Hallie Brown

13. Birthplace Norfolk Va.

MOTHER 14. Maiden Name Mary Berry

15. Birthplace Norfolk Va.

16 (a) Informant Elijah Johnson

(b) Address 904 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2nd 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto. Md.

18 (a) Funeral director Robert Francis & C. Wright

(b) Address [illegible]

(a) ____ (b) ____ (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 2 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypopituitarism (Simmond's disease)

Due to Cancer necrosis of hypophysis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frataw M.D. Medical Examiner.

Date signed June 29, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every item is especially important. Physicians: please write the causes of death clearly and legibly.

G 18616 16

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 18616 12 1a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 Aisquith St
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel A. Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Mary C. Chester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1892

8. AGE: Years	Months	Days	If less than one day
52	-	8	hr. min.

9. Birthplace Taylors Island Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Chester
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Bernbower
15. Birthplace Md

16 (a) Informant Mary Chester
(b) Address 420 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery or crematory
Location Taylors Island, Md.

18 (a) Funeral director Elroy O. Walson
(b) Address [illegible]

JUL 2 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28 1944 at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to June 28 1944 and that I last saw him alive on June 26 1944.

Immediate cause of death Chronic Nephritis (Uremia)
Due to
Due to
Other Conditions Anemia pulmonary & Apoplexy Hemiplegia
(Include pregnancy within 3 months of death)

Duration
6 mos

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph L. Yearney M. D.
Address 1424 E Madison Date signed 6/30/44

G 19617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 19617 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 Elsinor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Elsinor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Harvey McVeigh

3 (b) If veteran, name war

3 (c) Social Security Account No. 224-01-8359

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife MAUDE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1875

8. AGE: Years	Months	Days	If less than one day
69	1	12	hr. min.

9. Birthplace Culpeper Co. Va.
(Town, county, and state)
10. Usual Occupation Cashier (Bank)
11. Industry or business Retired

FATHER
12. Name Harvey McVeigh
13. Birthplace Va

MOTHER
14. Maiden Name Mary Richardson
15. Birthplace Va

16 (a) Informant Mrs. Low Sagraves
(b) Address 2410 Elsinor Ave.

17 (a) Removal (b) Date thereof July 2nd 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Elk Run
Location Elkton Va

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JUL 2 1944 (b)
(Date filed by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1944 at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to July 1 1944, and that I last saw h.m. alive on July 1 1944.

Immediate cause of death	Duration
Coronary occlusion	1 day.
Due to advanced arteriosclerosis ?	
Due to	
Other Conditions Myocarditis	3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hallie S Talbott M. D.
Address 2220 Garrison Blvd
(Attending physician or coroner)

July 1/44

G 18C18

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 463 B 18C18

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Johnstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 91 3rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Kleinstub
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Verena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-91

8. AGE: Years	Months	Days	If less than one day
53 52	3	21	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Hyman Kleinstub
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Eisenstein
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/1/44 (month) (day) (year)
(c) Cemetery or crematory Johnstown Pa.
Location

18 (a) Funeral director Sol Lerner Bros
(b) Address 112 [illegible] Ave Philadelphia, Pa.

19 (a) JUL 2 1944 (Date received by registrar) (b) Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944 to July 1 1944 and that I last saw h[illegible] alive on July 1 1944

Immediate cause of death Disseminated Carcinomatosis — Duration 3 mos

Due to Carcinoma of Stomach — ? 4 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March, 1944

Major findings of operation: Metastases to spine (thoracic) and

of autopsy Disseminated Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: X
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward E Bauman
Address Johns Hopkins Hosp. Date signed 7/1/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18618 ✓ G-18618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Canavan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Wh.
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 1884

8. AGE: Years 60 | Months 3 | Days 02 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Canavan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Clotsetty
15. Birthplace Ireland

16 (a) Informant Margaret M. Canavan
(b) Address 204 S Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross. Redeemer
Location Harford Road

18 (a) Funeral director John A Moran
(b) Address 3600 E Baltimore St

JUL 2 1944 (b) Registrar

VS 160

MEDICAL CERTIFICATION

28

20. DATE OF DEATH July 1 1944 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1944 to 7-1 1944 and that I last saw him alive on 6-30 1944

Immediate cause of death Cardiac failure — Duration

Due to Coronary thrombosis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 7-1-44

G 19626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G 19626

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3726 Cottage Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Kopald

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Tillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation none
11. Industry or business

MOTHER / FATHER
12. Name Solomon
13. Birthplace Austria
14. Maiden Name Segal
15. Birthplace Austria

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Park
Location Woodlawn Mem Park

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date received) Hutchins-Williams M.D. Registrar

JUL 2 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20, 1944, to July 1, 1944, and that I last saw him alive on June 30, 1944.

Immediate cause of death a) Carcinoma of rectum. b) - Uremia.

Due to

Due to

Other Conditions Arteriosclerosis and cardiac failure.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel Shipley, M.D. M.D.

Address 1814 Eutaw Place Date signed July 3 1944

G 13621 G 13621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richland St & Rayner Ave.
(c) Hospital or institution: WBGH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Walson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 7-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Helen Freemasons
Location Balto & Conkling Sts

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar) Registrar

JUL 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1944 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1944 to 6/29 1944, and that I last saw her alive on 6/29 1944.

Immediate cause of death	Duration
Myocardial Infarction	2 mos.
Due to Old Coronary Thrombosis	2 mos.
Due to Acute Coronary Thrombosis	1 day
Other Conditions HCVD Compensated	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Taylor M.D.

Address WBGH. Date signed 6/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 18622 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3249 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) about 70 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 13
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3249 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob A Hace
3 (b) If veteran, name war
3 (c) Social Security Account No. none
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Rachael
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 3 - 1863
8. AGE: Years 80 Months 11 Days 27 If less than one day hr. min.
9. Birthplace Connecticut (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Penn. R. R.

FATHER
12. Name unknown
13. Birthplace Conn.

MOTHER
14. Maiden Name unknown
15. Birthplace Conn.

16 (a) Informant Mrs Lillian Hace
(b) Address 3249 Chestnut Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory St Mary
Location Hampden Balto Md
18 (a) Funeral director Frank H Seitz
(b) Address 914 N 36 St.
19 (a) Date received by registrar — 1944 — (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944 at 4 P M
21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to July 1 1944, and that I last saw h[illegible] alive on June 30 1944

Immediate cause of death Myocardial Insufficiency — Duration —
Due to Arteriosclerosis — Duration —
Due to Cardiac disease — Duration 3
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —
23. Signature [illegible] M. D.
Address 3429 Spaulding Ave Date signed July 1 44

G 18623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G 18623

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -----
(e) Length of stay in Baltimore (yrs., mos., or days) 82 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? ----- -- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Mary Ann Freeman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) May 16, 1862

8. AGE: Years	Months	Days	If less than one day
82	1	13	---hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name James Freeman
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Gorman
15. Birthplace Ireland

16 (a) Informant Miss Mary G. Freeman
(b) Address 4203 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. U. Meares & Son
(b) Address 805 N. Calvert Street

19 JUL 2 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6- 29 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from ——— 1920 to 6- 29 1944, and that I last saw h. Or alive on 6- 29 1944

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to Cardiac dilatation	
Due to Hypertension + arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. H. Hayward
Address 115 E. Eager St. Date signed 7/1- 1944 M. D.

G 18624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G 18624

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Eutaw Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Simmant, Mr Frederick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1867

8. AGE: Years	Months	Days	If less than one day
77	—	—	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Simmant, Edward
13. Birthplace Balto.

MOTHER
14. Maiden Name Holingshead, Elizabeth
15. Birthplace Balto.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address

19 (a) 7-2-1944 (Date rec'd by registrar) (b) Herrington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1944, to June 30 1944, and that I last saw him alive on June 30 1944.

Immediate cause of death	Duration
Epithelioma of face	
Due to Osteomyelitis of skull	
Due to Ulceration of Epithelioma of face	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: as stated above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Vernon H. Howard
Address Church Home & Hospital Date signed 7-3-44

G 19625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 19625

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Diamond St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James, William

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1902

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm Jones
13. Birthplace N.C.

MOTHER
14. Maiden Name Matilda Braxton
15. Birthplace Braxton, Va.

16 (a) Informant Matilda Jones
(b) Address 316 Diamond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
(Address given by registrant) (Name of city or town) Baltimore, Md.

JUL 2 1944
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to June 30 1944, and that I last saw deceased alive on June 30 1944

Immediate cause of death: Pulmonary hemorrhage
Due to (Hodgkins Disease) Malignant Lymphoma
Due to involving abdomen mediastinum & pleura
Other Conditions Rheumatism
Cardio vascular disease
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leroy W. Taylor M. D.
Address University Hospital Date signed 6-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Insect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18526 ✓ G 18526

AB-88766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 4hrs-20min.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2010 Llewelyn Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kirk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.-27-1882

8. AGE: Years	Months	Days	If less than one day
62	5	2	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name ?

13. Birthplace N.C.

MOTHER

14. Maiden Name Jane Kirk

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof July 3 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halsted

(b) Address 918 Druid Hill Ave

19 (a) (b)
Date filed by registrar Burial

2-1944 W-42

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29- 1944, at 3.55P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944, to 6-29 1944 and that I last saw h.i. alive on 6-29 1944

Immediate cause of death Cardiac failure — Duration 4 min

Due to Arterio sclerotic heart disease — 4 Years

Due to Bronchopneumonia — 4 Days

Other Conditions Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul Mattina

Address B. C. H. Date signed 7/1/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 13022 ✓ G 13022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N. Bradford St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Bradford St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Klima

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank Klima
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Not Known
8. AGE: Years 92 Months Days If less than one day hr. min.
9. Birthplace: Czecho-slovakia (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business

FATHER
12. Name: Anthony Karvasek
13. Birthplace: Czecho-slovakia

MOTHER
14. Maiden Name: Anna Herold
15. Birthplace: Czecho-slovakia

16 (a) Informant: Barbara Klima
(b) Address: 914 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto Md.

18 (a) Funeral director: Francis Lucas & Son
(b) Address: 900 N. Chester St.
(Date) JUL 2 - 1944 (Registrar) Huntington Williams, M.D. Registrar

V8 8

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to June 29 1944 and that I last saw her alive on June 29 1944

Immediate cause of death: Uraemia — Duration: 5 days
Due to: Chronic Interstitial Nephritis — ?
Due to:
Other Conditions: Chr. Myocardial Degeneration — ?
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: Vincent F. Dooka M. D.
Address: 845 N. Patterson Pk. Ave. Date signed: 6/30/44

G 18628 G 18628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6414 Brook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6414 Brook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE E. MARCK

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-7540

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Flora Marck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1884

8. AGE: Years	Months	Days	If less than one day
60	0	0	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Maintenance Man.
11. Industry or business Printing Co.

FATHER
12. Name Geo. D. Marck
13. Birthplace Unknown

MOTHER
14. Maiden Name Eliz. ----
15. Birthplace Germany

16 (a) Informant Mrs. G. E. Marck
(b) Address 6414 Brook Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof July 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director Lorsch Funeral Home
(b) Address 7401 Belair Road
(c) [illegible] Washington Williams M.D.

JUL 2 - 1944 (Date received by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1944, at 3:43 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1944 to 6/30 1944 and that I last saw h[illegible] alive on 6/25 1944.

Immediate cause of death Cardiac failure — Duration 3 weeks
Due to arteriosclerotic — Duration 2 yr.
Due to Cardio Vascular Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. A. Scott M. D.
Address 5400 Harford Date signed 7/1/44

C 18629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

C 18629

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3911 Kennison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Lakeland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Rohnacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife John L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1882

8. AGE: Years	Months	Days	If less than one day
62.	2	20	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Geo. Dietz
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. John L. Rohnacher
(b) Address 613 Lakeland St.

17 (a) Burial (b) Date thereof 9-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md.

18 (a) Funeral director Harry A. Witzke
(b) Address 1012 Edmondson Ave.

19 (a) AUG 2 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 11a. M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 27 1944 to JUNE 30 1944, and that I last saw her alive on JUNE 30 1944.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	√ DAYS
Due to HYPERTENSION	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Hoffman M. D.
Address 8 East Read St Date signed 7/14/44
M. D.

G 18630

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1637

G 18630 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2142 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Kathryn Vildt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1888

8. AGE: Years 55 | Months 6 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Telephone Operator

11. Industry or business Bon Secours Hospital

FATHER
12. Name Mathias Vildt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kneis
15. Birthplace Germany

16 (a) Informant Mrs. Anna T. Vildt
(b) Address 2142 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4200 Belair Rd

18 (a) Funeral director Henry H. Wilhelm
(b) Address 401 E. Lanvale Ave

19 (a) JUL 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944, at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1944 to 7-1 1944 and that I last saw he alive on 6-30 1944.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Thyroid Crisis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel, Jr. M. D.
Address Bon Secours Hosp Date signed 7-1-44

VS 2

G 12631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 12631 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Cayon St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2533 Lanvale Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Joseph F. Carey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 21, 1916
8. AGE: Years 28 | Months 4 | Days 9 10 | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Roscoe C. Younts
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary E. Nichols
15. Birthplace N. C.

16 (a) Informant Mrs. R. L. New
(b) Address 709 Lyndhurst St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md
18 (a) Funeral director Harry H. Wiltshire
(b) Address 4101 E Monument St
19 (a) JUL 2 1944 (Date rec'd by registrar) (b) Washington Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944, at 5.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 1944 to 7-1 1944; and that I last saw h.e alive on 5-30 1944

Immediate cause of death	Duration
Uremia	
Due to Acute Glomer. Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel Jr. M. D.
Address Bon Secours Hosp Date signed 7-1-44

G 12632 CLAWSON G 12632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6110 Glen Oak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6110 Glen Oak Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Clawson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: late Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-1861

8. AGE: Years	Months	Days	If less than one day
82	6	11	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business R.R.

FATHER
12. Name — Clawson
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs E Lyvia Caroline
(b) Address 6110 Glen Oak Ave

17 (a) Burial (b) Date thereof 7-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Harry H Wilkes
(b) Address 1101 Edmondson Ave

19 (a) 7-2-1944 Washington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1944, at 3:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1944, to June 29 1944, and that I last saw him alive on June 29 1944

Immediate cause of death: Chronic Myocarditis — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Gale M. D.
Address 6014 York Road Date signed 6-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct [illegible] is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 18633 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 S. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 S. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph J. Walling

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widower

6 (b) Name of husband or wife late Laura Staley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1855

8. AGE: Years	Months	Days	If less than one day
88	9	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Walling
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Fleming
15. Birthplace Maryland

16 (a) Informant Mrs. Betty Pennington
(b) Address 907 S. Paca St

17 (a) Burial (b) Date thereof 7-3-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Harry A. Wittke
(b) Address 16 Edmondson Ave.

19 (a) JUL 2 - 1944 Huntington Hillmann, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1934 to 6-30 1944
and that I last saw h. alive on 6-30 1944

Immediate cause of death: Acute Cardiac Failure — Duration 1 da

Due to: Hemorrhage Arteriosclerosis — 10 yrs

Due to: Cerebral Embolism — 1 day

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph G. Laubach M.D.
Address 1316 Washington Blvd Date signed 7/1/44

G 18634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 18634 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 N Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Julia Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband ~~or wife~~ Slater

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1885

8. AGE: Years 58 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Richond Co. Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Rubin Shelton
13. Birthplace Richond Co Va

MOTHER
14. Maiden Name Julia Ann Venney
15. Birthplace Richond Co. Va

16 (a) Informant Evelyn Hopkins
(b) Address 531 N. Dallas St

17 (a) Burial (b) Date thereof July 3-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Richmond, Co. Va

18 (a) Funeral director Robert Grilliam
(b) Address 1515 McCallery St

19 (a) [illegible] (b) Huntington, West Va

JUL 2 - 1944

4-150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1944 to June 29 1944 and that I last saw her alive on June 29 1944

Immediate cause of death Cerebral hemmorrhage — Duration 2 hr

Due to Myocarditis

Due to Nephrosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Lafayette M. D.
Address 822 N. Broad St Date signed 7/1/44

G 18035 G 18035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 164 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City [redacted] A.A. County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 162 Meadow Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Appetito

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-12-02

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan. 21-1923
8. AGE: Years 21 | Months 3 | Days 29 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Electric welder
11. Industry or business Bethlehem Steel Co., Key Hwy.

FATHER
12. Name Alfred A. Appetito
13. Birthplace Rome, Italy

MOTHER
14. Maiden Name Blanche E. Vogel
15. Birthplace Baltimore, Md.

16 (a) Informant Alfred A. Appetito
(b) Address 162 Meadow Rd, A.A. Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A.A. Co., Md.

18 (a) Funeral director A. J. Howard Evans
(b) Address 1400-02 St. Charles St., Balto.

19 (a) JUL 2 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)
VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30- 1944, at 9:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shotgun wound of Brain

Due to

Other Conditions Apparently Despondent.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-30-44 at 9.40 A M.
(b) Where did injury occur? My Penitentiary
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shotgun - 12 gauge, mouth.

Signature Thomas J. Mackin M.D.
Medical Examiner.
Date signed 6-30-44

G 10635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 300 S Franklintown Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Y

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 300 S Franklintown Rd (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Thomas O Baker

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7th 1861

8. AGE: Years 83 | Months -- 1 | Days - 24 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business City Of Baltimore

FATHER

12. Name Jacob Baker

13. Birthplace Baltomore Md.

MOTHER

14. Maiden Name Catherine Brady

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Charelett Saunders

(b) Address 816 Primsen Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July4th44 (month) (day) (year)

(c) Cemetery or crematory St Peters Cem

Location Baltimore Md.

18 (a) Funeral director Milton Schilling

(b) Address 1914 S Hanover Street

19 (a) ..... (Date rec'd by registrar) JUL 3 1944 (Huntington for Millington, MD)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 44 19 5.50A M M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 19 44, to June 22 19 44, and that I last saw h. alive on June 30 19 44.

Immediate cause of death ..... Duration

Acute cardiac Dilatation 3 days

Due to Chr. Myocarditis 2

Due to .....

Other Conditions Arterio Sclerosis ?

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Henry Glassman M. D.

Address 2601 Madison Ave Date signed June 30 1944

G 18037 Gleason / G 18037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1839 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 W. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Gleason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 1886

8. AGE: Years 57 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Clerk.

11. Industry or business Gov. Dept Wash D.C.

FATHER
12. Name Michael Gleason
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Crawley
15. Birthplace Ireland

16 (a) Informant Mrs Anna R. Gleason
(b) Address 1839 W. Baltimore St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 908-08 Hollins St.

19 (a) 6/30/1944 (Date rec'd by registrar) (b) Washington Williams Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to June 29 1944, and that I last saw h alive on June 27 1944.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	6 mo
Due to Arteriosclerotic Cardiosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester L. Lubrecht M.D.
Address 5217 Park Heights Ave 6/30/44

G 19633 Gaffney G 19633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 944a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 S. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 S. Schroeder St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Gaffney

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie J. Gaffney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 3rd 1895

8. AGE: Years 49 | Months — | Days 28 | If less than one day hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business

FATHER: 12. Name: William Gaffney
13. Birthplace: Ireland

MOTHER: 14. Maiden Name: Johanna Nelson
15. Birthplace: Ireland

16 (a) Informant: Mrs Elsie J. Gaffney
(b) Address: 123 S. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/1944 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cath Cem
Location: 5501 Frederick Ave

18 (a) Funeral director: John Conway & Son
(b) Address: 901-03 Gilmor St.

19 7-9-1944 (Date received by registrar) (b) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944 at 2 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to June 30 1944 and that I last saw him alive on June 29 1944

Immediate cause of death: Coronary Thrombosis — Duration 1 dy

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Huntington Williams M. D.

Address: 527 Park Ave. Date signed 9/6/44

C 19638 C 19639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Warner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Warner St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert L. Powell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Kate Mary Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1872

8. AGE: Years 71 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Mrs Herbert Garland
(b) Address 707 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2930 Frederick Ave

18 (a) Funeral director John L Cowan Co
(b) Address 901-03 Gallows St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1944 to June 30 1944 and that I last saw him alive on June 29 1944

	Duration
Immediate cause of death: Cystitis	2 days
Due to: Prostatic Hypertrophy	6 mos.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Goodwin
Address 1 E. Randall Date signed 7/3/44

G 18640 ✓ G 18640

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 52B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Roessner ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charles V. Stone

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sue Stone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-83

8. AGE: Years 61 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Henry Stone
13. Birthplace (W. Va)

MOTHER 14. Maiden Name Sue Kershner
15. Birthplace (Md)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/44 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem.
Location Hagerstown Md.

18 (a) Funeral director A. K. Hoffman
(b) Address Hagerstown Md.

19 (a) [illegible] (b) [illegible]

JUL 3 - 1944

VS 150

JUL 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1-1944 at 6 32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11-1944 to 7-1-1944 and that I last saw him alive on 7-1-1944

Immediate cause of death: Bronchopneumonia
Due to: Carcinoma of bladder
Due to:
Other Conditions: Generalized Arteriosclerosis

Duration

(Include pregnancy within 3 months of death)
Date of operation June 19, 1944
Major findings of operation: Extension Carcinoma bladder
of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Price M.D.
Address Johns Hopkins Hosp Date signed 7/2/44

G 18641 — 43

Rothaus ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G 18641 — Registered No.

MARRIED RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5868 Belair Rd
(c) Hospital or institution: 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5868 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Marie Rothaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry F.

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb 30 1893

8. AGE: Years	Months	Days	If less than one day
51	4	10	hr. min.

9. Birthplace Chaska Minn. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER — 12. Name Julius Bielke

13. Birthplace Germany

MOTHER — 14. Maiden Name Bertha Kluge

15. Birthplace Germany

16 (a) Informant Mr. Harry F. Rothaus

(b) Address 5868 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Old Harford Rd

19 JUL 3 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 2.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to June 30 1944, and that I last saw her alive on June 30 1944

Immediate cause of death: Carcinoma Left Ovary — Duration am 3 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1944

Major findings of operation: Carcinoma Left Ovary.

of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?

(e) Means of injury —

23. Signature Carey Rowling M. D.

Address 131 N. St. Lombard St Date signed 7/1/44

C 18642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

C 18642 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 E. 30th st
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 E. 30th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice M. Winstead

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Surdowed

6 (b) Name of husband or wife: John Winstead

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct. 26 1864

8. AGE: Years 79 | Months 8 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Bdown
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Shaver
(b) Address 1705 E. 30th st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 3 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Philip Hezius Sons
(b) Address 202 Orleans st

19 JUL 3 - 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to June 30 1944, and that I last saw her alive on June 30 1944.

Immediate cause of death: Hemorrhage (2. Pulmonary ?) — Duration: 2 weeks
Due to Arterio sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed L. Zimmerman M. D.
Address 9858 Reisterstown Rd Date signed 7-1-44

G 18643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 18643 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Nursing Home 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Mewington Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Ford Hicks.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Francis Hicks

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 16-1854

8. AGE: Years 90 | Months — | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business at Home

FATHER
12. Name Thomas Ford
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Fanning
15. Birthplace Dont Know.

16 (a) Informant Mrs. Elizabeth C.H. Hay
(b) Address 712 Mewington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JUL 3 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

18 (a) Funeral director Chas. J. Evans & Son Inc.

(b) Address 118 N. Mt. Royal Ave

JUL 3 1944 (Local rec'd dd/registrar) (b) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944 at 6.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to June 30 1944, and that I last saw h[illegible] alive on June 30 1944.

Immediate cause of death — Duration

Due to Chr. Myocarditis — 9 35

Due to Chr. Interstitial Nephritis — 9 35

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown

Address 1663 W. Pratt St. Date signed 7/1/44

G 18644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 18644 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Katz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. N. Nash (Daughter)
(b) Address 3511 Wabash Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jos. Heiras Inc
(b) Address 1401 E. Baltimore St (Funeral home) Huntington Williams, Md.

7 JUL 3 - 1944 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1944, at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1944, to 7/2/44 19..., and that I last saw h... alive on ... 19...

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Hypertension	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Enlarged Heart
of autopsy: Coronary Sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Perino
Address Sinai Hosp. Date signed M. 7 D. 2/44

G 18645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G 18645

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: 15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md (If outside city or town limits write RURAL and give town)
(d) Street No. 3928 Pentelarm Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB BALK

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rebecca Balk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/83

8. AGE: Years 61 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Watch maker

11. Industry or business

FATHER
12. Name Leon Balk
13. Birthplace Russia

MOTHER
14. Maiden Name Reva
15. Birthplace Russia

16 (a) Informant Sidney Balk (Brother)
(b) Address 3942 Reis. Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale Cem.
Location 1439 E. Balto. St

18 (a) Funeral director Jos Reuss Sr
(b) Address 439 E. Balto. St Huntington Williams, Md.

JUL 3 - 1944 (Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1944, at 10:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1944, to 7/2 1944, and that I last saw him alive on 7/2 1944.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Coronary Sclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/1/44

Major findings of operation CA Stomach

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Jane Foley

Address Mercy Hosp Date signed 7/2/44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 13646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 E. Centre St.
(c) Hospital or institution: 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 E. Centre St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Helen Heems

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1881

8. AGE: Years 63 62 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Charles Co. Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name John Henry Hood

13. Birthplace Charles Co. Md.

MOTHER 14. Maiden Name Mary Jane Kelly

15. Birthplace Charles Co. Md.

16 (a) Informant Mary Hood

(b) Address 112 E. Centre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1944 (month, day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JUL 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to June 29 1944, and that I last saw her alive on June 28 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Hypertensive Cardio-Vascular-renal disease	
Due to	
Other Conditions Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isadore Shapiro M.D.

Address 6017 N. Monroe St. Date signed 7/1/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G 18642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. G 18642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Balto City
(b) Street address 1402 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED: 1402 Madison Ave
(a) State Md (b) County Balto
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Madison Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME James Allen Gates

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 - 1872

8. AGE: Years 71 | Months 6 | Days 8 | If less than one day hr. — min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none
11. Industry or business —

FATHER
12. Name James Gates
13. Birthplace Md

MOTHER
14. Maiden Name Ingram
15. Birthplace Md

16 (a) Informant Miss Ester Johnson
(b) Address 1402 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 3 - 44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Mrs Geo H. Holland
(b) Address 1631 Hanover Hutchins Ave Huntsville or Millsville, Md.

JUL 3 - 1944
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944, to June 30 1944, and that I last saw him alive on June 29 1944

Immediate cause of death	Duration
Paralysis	6 days
Due to Hypertension	
Due to —	
Other Conditions Age	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature James C Cayton
Address 1433 Madison Ave Date signed 6/30/44 (M.D.)

G 18648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

V G 18648 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Presstman St.
(c) Hospital or institution: none 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Presstman St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Lantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Frederick W. Lantz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1857

8. AGE: Years 87 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation housewffe

11. Industry or business

FATHER
12. Name Adam Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Anna
15. Birthplace Germany

16 (a) Informant Miss E. Elfleda Lantz
(b) Address 3017 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 JUL 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 1, 1944, at 12/45M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to July 1 1944, and that I last saw h[illegible] alive on July 1 1944.

Immediate cause of death	Duration
Chronic cardiovas	7 yrs
Due to decay	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grant W. Rahn
Address 1735 Poplar Grove St. Date signed 7/3/44

MARK RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

C 10649 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Chelsea Terr.
(c) Hospital or institution:
15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Chelsea Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. WHEAT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Olive M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1887

8. AGE: Years 57 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Real Estate
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace --

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mr. R. M. Wheat
(b) Address 2224 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 3 - 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1944, to July 1 1944, and that I last saw h-- alive on July 1 1944.

	Duration
Immediate cause of death: Coronary occlusion	1 hr.
Due to: Arteriosclerosis	?
Due to:	
Other Conditions: myocarditis	about 2 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Tilbutt M. D.
Address 2220 Garrison Blvd. Date signed July 2/44

18650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

✓ G 18650 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Sidehill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Harry~~ Harold Abrahams

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1888

8. AGE: Years	Months	Days	If less than one day
55	8	19	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Solicitor
11. Industry or business Davidson Transfer Co.

FATHER
12. Name Charles E. Abrahams
13. Birthplace Port Deposit, Md

MOTHER
14. Maiden Name Ida Summers
15. Birthplace Balto., Maryland

16 (a) Informant Mrs. Inez Abrahams
(b) Address 4400 Sidehill Road

17 (a) Burial (b) Date thereof 7/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Dickens & Son
(b) Address Balto., Md.

19 (a) JUL 3 - 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1944, at 11 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Ruptured Heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-29- at 11 P. M.
(b) Where did injury occur Johnny Cake Rd & Route 40
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in automobile

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 6-30-44

(over)

G 18651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 18651 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days) 66 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob G. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary R. King

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov 4-1877

8. AGE: Years 66 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. MD. (Town, county, and state)

10. Usual Occupation B & O. R.R.

11. Industry or business

FATHER — 12. Name John Henry Smith
13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Elizabeth Stanger
15. Birthplace Balto. Maryland

16 (a) Informant Mary R. Smith
(b) Address 2111 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Thomas J. Kenney
(b) Address Hollins & Fulmer Sts.

JUL 3-1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30/44 19 , at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10/44 19 , to 6/30/44 19 , and that I last saw him alive on 6/29 19 44

Immediate cause of death: Acute cardiac dilatation — Duration: 2 days

Due to: Senility - Chronic

Due to: myocarditis — 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Pelas M. D.
Address 47 N. Fulton Date signed

18652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 18652

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver
(c) Hospital or institution St. Joseph's Hospital 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Ailsa Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Ann Mason

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1944

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Paul A. Mason
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elsie M. Selby
15. Birthplace Baltimore Md

16 (a) Informant Paul A. Mason
(b) Address 2603 Ailsa Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 801 N. Fayette St

19 (a) Date JUL 3 1944 (b) Huntington Williams, M.D.

VS-180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 2 1944 and that I last saw h[illegible] alive on July 1 1944.

Immediate cause of death
1. Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. H. E. Wallace

Address 1400 N. Carey St Date signed 7/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. C-18653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Fairfield Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1443 Chesapeake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Elinskey = GLODEK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband ~~Frank~~ ADOLPH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 4-1891

8. AGE: Years	Months	Days	If less than one day
53	4	27	hr. min.

9. Birthplace BALTIMORE Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ciozewski
13. Birthplace ?

MOTHER
14. Maiden Name Mary Clement
15. Birthplace ?

16 (a) Informant Matilda Snyder
(b) Address 1503 Webster st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn A.A. Co.

18 (a) Funeral director Reese R Wilber
(b) Address 705 S Pinn st

19 JUL 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944, at 1 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to July 1 1944, and that I last saw h.e.r alive on July 1 1944.

Immediate cause of death Carcinoma of the liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Zuckerman M.D.
Address 1213 Light St. Date signed 7/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND LAW REQUIRED FOR BURIAL PERMIT

RESERVED

12654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G 18654
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Bentalou Rd. ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lee Domowski

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1942

8. AGE: Years 1 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Alexander Domowski
13. Birthplace Poland

MOTHER
14. Maiden Name Virginia Jenkins
15. Birthplace Cambridge Md.

16 (a) Informant Mrs. Marie Schweeler
(b) Address 1615 Ben Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1425 Light St.

19 (a) JUL 3 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1944, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inspection & autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratz M.D. Medical Examiner.
Date signed July 1, 1944

VS 151

G 18655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 18655

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Every item should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto – 1. (If outside city or town limits, write RURAL and give town)
(d) Street No. University Club. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Henry L. D. Stanford, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-'97

8. AGE: Years 46 | Months 8 | Days 25. | If less than one day ... hr. ... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation lawyer.

11. Industry or business law.

FATHER 12. Name Henry L. D. Stanford.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Maria E. Wallen.
15. Birthplace Maryland.

16 (a) Informant self.
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/4/44 (month) (day) (year)
(c) Cemetery or crematory St Andrews. Cem
Location Princess Anne. Md.

18 (a) Funeral director Wm Cook Jr.
(b) Address 217 St Paul St. Huntington Williams, Mgr.

19 (Date received by registrar) JUL 3 – 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944, at 6.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw him alive on July 19

Immediate cause of death cardio-respiratory failure | Duration

Due to Hypertensive cardiovascular

Due to disease – cerebro-vascular

Other Conditions accident.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chiffelle M. D.
Address Union Memorial Hospital Date signed 7-2-44

G 13656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13656

Registered No. .....

TO #15845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Baltimore City Hospitals 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-1--& 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Shuter St.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Florence Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married Separated

6 (b) Name of husband or wife Fred
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1873

8. AGE: Years	Months	Days	If less than one day
70	10	14	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Eccleston
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Burke
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month, day, year)
(c) Cemetery or crematory London Pk. Cem.
Location Baltimore
18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.
19 (a) JUL 3 - 1944 (Registrar's) Huntington Williams, M.D.
(b) Received by registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1944, at 7:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1939 to 6/30 1944 and that I last saw h[illegible] alive on 6/30 1944.

Immediate cause of death	Duration
Congestive failure	?
Due to Arteriosclerotic heart disease	?
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Paul Hartman M.D.
Address B.C.H. Date signed 7/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGINS RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18652

T.O.P.--88728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 18652
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1068 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME
John Hammond,

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-7161

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1885(?)

8. AGE: Years	Months	Days	If less than one day
58 59 ?	5 ? 6	4 ?	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Brick Yard Work
11. Industry or business

FATHER
12. Name John Hammond
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Sorrell
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Buried (b) Date thereof 7-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans.
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 522 N. Belnord Ave.
19 JUL 3 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1944, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27 1944 to 6/29 1944 and that I last saw him alive on 6/29 1944.

Immediate cause of death	Duration
Thrombus pulmonary embolus & infarction, ?	
Due to Prob. Thrombophlebitis of legs	
Other Conditions ASCVD c failure;	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
as above; card. hypertrophy;
of autopsy: C P C of Hines

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Seligman M.D.
Address BCH Date signed 6/30

TACKETT

G 19658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G 19658

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits write RURAL and give town)
(d) Street No. 1610 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rogers Tackett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1909

8. AGE: Years 34 | Months 11 | Days 12 | 4 If less than one day hr. min.

9. Birthplace Warrington Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel

FATHER
12. Name Richard Tackett
13. Birthplace Va

MOTHER
14. Maiden Name Louisiana ?
15. Birthplace V.

16 (a) Informant Florence Tackett
(b) Address 1610 W. Lanvale St.

17 (a) Burial (b) Date thereof 7-6-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Warrington Va

18 (a) Funeral director Samuel W. Sullivan & Son (d) Means of injury Fire-com
(b) Address 117 W. Camden St Balto

19 (c) JUL 3 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH July 2, 1944 at 4 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun shot of Heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/2/44 at 3 46 A M.
(b) Where did injury occur? 1626 W Lanvale St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 7-2-44

VS 151

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56B

G 18659 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Mount St
(c) Hospital or institution:
15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Regina Simms Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Willie Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1891

8. AGE: Years	Months	Days	If less than one day
52	10	11	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nathan Brewer
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Dodson
15. Birthplace Md.

16 (a) Informant Lizzie Brewer
(b) Address 1304 Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Geo. L. Kelson
(b) Address 1303 Pressman St

19 (a) JUL 3 - 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 44, at 9:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 19 44, to June 30 19 44, and that I last saw her alive on June 30 19 44.

Immediate cause of death Cardio Vascular Disease — Duration 6 hrs's

Due to Broken Compensation — 3 mo's

Due to Fibroid Tumor of Uterus — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. William Fley M. D.
Address 908 Druid Ave Date signed 7/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

13660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 460

G 13660
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital - 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 East Clement St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Richard A. Stickels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Ollie.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/25/1879

8. AGE: Years	Months	Days	If less than one day
65	1	6	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Car Builder.
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 505 E. Clement St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Washington Va.

18 (a) Funeral director L. H. Caulk
(b) Address 620 E. Fort Ave.

JUL 3-1944
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/1944 at 4:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14/1944 to 7/1/1944, and that I last saw h... alive on 7/1/1944.

Immediate cause of death	Duration
Pneumonia -	
Due to Post operative Gastro-enterostomy	
Due to Ca of Stomach -	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/20/1944

Major findings of operation: Carcinoma of lesser curvature Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan
Address St Joseph Hospital Date signed 7-7-44

G 18661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 18661

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4507 Rolandale
(c) Hospital or institution: at home 3 - 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4507 Rolandale (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Cecilia Brady

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank P. Brady
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-29-1868

8. AGE: Years 75 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Charles Frainie
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Weisel
15. Birthplace Germany

16 (a) Informant E. Philip Brady - son.
(b) Address 4507 Rolandale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sullivan Memorial Co.,
(b) Address 108 W. Mt. Royal Ave.

19 (Date received by registrar) JUL 3 - 1944 Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944, at 9.58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to July 1 1944, and that I last saw h er alive on July 1 1944

Immediate cause of death Coronary Thrombosis — Duration 4 days

Due to Arteriosclerosis & Hypertension, Arteriosclerotic Ht. Disease — Years Years

Due to

Other Conditions Diabetes Mellitus — Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert W. Garis

Address 1014 St. Paul St Date signed M. 7 D. 2 1944

G 18662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 18662 Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.0.4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clayton Otto Bosley

3 (b) If veteran, name war: World Are 11
3 (c) Social Security Account No. 048-03-6063

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marjorie MacIntyre
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1911

8. AGE: Years 32 | Months 8 | Days 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Chauffeur
11. Industry or business: Rice Bakery Co

FATHER
12. Name: Abram Watson Bosley
13. Birthplace: Balto. Co

MOTHER
14. Maiden Name: Minnie Pfort
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Marjorie MacIntyre Bosley
(b) Address: 1328 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave & Broadway

19 (a) JUL 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944 at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/1/44 at 2 P. M.
(b) Where did injury occur? Horn Ave. & Belair Rd
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? yes
(d) Means of injury Driver - Overturned auto truck

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 7-2-44

G 18663 G 18663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Parkside prive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna DeWald

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles H. DeWald
6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 12, 1880

8. AGE: Years	Months	Days	If less than one day
63	11	18	hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: ? Burgemeister
13. Birthplace: Germany

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mr. Charles H. DeWald
(b) Address: 3006 Parkside Dr. - 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave & Broadway

19 Date rec'd by Registrar: JUL 3 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on June 30 1944.

Immediate cause of death: metastatic carcinoma uraemia — Duration: May 1943

Due to: Malignant papilloma, rt. Kidney (removed 1942)

Due to:

Other Conditions: Anaemia, hypertension (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charlotte McCarthy M. D.
Address: Medical Arts Bldg. Date signed: July 3, 44

G 13664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13664 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2532 Boyd St.
(c) Hospital or institution: 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Boyd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Ring

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Michael Ring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1868

8. AGE: Years	Months	Days	If less than one day
75	8	25	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

MOTHER / FATHER
12. Name Houck
13. Birthplace Hungary
14. Maiden Name
15. Birthplace Hungary

16 (a) Informant Michael Ring
(b) Address 2532 Boyd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/44 (Month) (Day) (Year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave

18 (a) Funeral director Harry H. Mitte
(b) Address 4101 Edmondson Ave

19 JUL 3 - 1944 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30/44 19 3 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1944 to June 30 1944, and that I last saw alive on June 25 1944.

Immediate cause of death	Duration
Myocardial insufficiency	Unknown
Chronic arteriosclerotic heart disease with hypertension	4 years
Due to auricular fibrillation and congestive failure.	
Due to Fractured right femur	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. Michel M. D.
Address 4101 Edmondson Ave Date signed July 3 1944

18665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

C 18665
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Etting St.
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Etting (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Bennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mike
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3-1899

8. AGE: Years 45 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Abbeville S.C. (Town, county, and state)

10. Usual Occupation Housedress

11. Industry or business

FATHER 12. Name Belton Preston
13. Birthplace S.C.

MOTHER 14. Maiden Name Lula Mayfield
15. Birthplace S.C.

16 (a) Informant Mike Bennett
(b) Address Jacksonville N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-44 (month) (day) (year)
(c) Cemetery or crematory New Prospect
Location Abbeville S.C.

18 (a) Funeral director Samuel N. Sullivan Jr.
(b) Address 1170 N. Carrollton Ave

19 (a) JUL 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to June 28 1944 and that I last saw her alive on June 27 1944.

Immediate cause of death	Duration
Lobar pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M. D.
Address 718 Dolphin St. Date signed 7-2-44

G 18666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G 18666 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 W Hill Street
(c) Hospital or institution:
22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 W. Hill St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thaddeus Burrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1869

8. AGE: Years 55 | Months 3 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Va (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Burrell
13. Birthplace Va

MOTHER
14. Maiden Name Mary Harris
15. Birthplace Va

16 (a) Informant India Nelson
(b) Address 124 W West Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location 1 A Co Md

18 (a) Funeral director Isaiah Brown Son
(b) Address 1056 W North Ave

JUL 3 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 1944 at 5:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1944 to 6/30 1944 and that I last saw him alive on 6/30 1944

Immediate cause of death Chronic Ulcerative Pyelonephritis

Due to Carcinoma of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Swanlee M. D.

Address Lee Date signed 7/1/44

G 13662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13662 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: St Joseph Hosp 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B.A.Co.
(c) City or town [redacted] Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Rivercliff Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Billy Faust

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1937

8. AGE: Years 7 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Opp Ala (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Geo Hugo Faust
13. Birthplace Alabama

MOTHER 14. Maiden Name Gloria Johns
15. Birthplace Alabama

16 (a) Informant Mr John P Johns
(b) Address 321 Riverside Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6, 44 (month) (day) (year)

(c) Cemetery or crematory Sun Set Cem
Location Berkley W. Va

18 (a) Funeral director Whitney Schilling
(b) Address 391 S. Hanover St. Balto 25 Md

19 JUL 3 - 1944 (b) Registered
Date rec'd by Local Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1944 to 7-3 1944, and that I last saw h.[illegible] alive on 7-3 1944.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Diabetes mellitus acidosis & coma.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jones M.D.
Address St Joseph Hospital Date signed 7-3-44

G 18668 ✓ G 18668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3819 S. Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 S. Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Witzel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary B. Witzel
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) May 3 - 1852

8. AGE: Years 92 | Months 1 | Days 27 | If less than one day hr. 8 min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew Witzel
13. Birthplace Germany

MOTHER
14. Maiden Name Odelia ?
15. Birthplace Germany

16 (a) Informant Mrs. John Witzel
(b) Address 3819 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4-1944 (month, day) (year)
(c) Cemetery or crematory Holy Cross
Location Pulaski Highway & G. Lea.

18 (a) Funeral director Elizabeth Hartle Inc.
(b) Address 115 E. West St.

19 (a) (Signature of registrar) Huntington Williams M.D.

JUL 4 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to July 1, 1944, and that I last saw ~~him~~ alive on July 1, 1944.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Senility	
Other Conditions Cerebral Deleterium	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent M. Massara
Address 1403 S. Charles St Date signed 7/1/44

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18663 ✓ G 18663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caroline
(c) Hospital or institution Bon Secours Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Middle River Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Fuselage Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Plyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Harvey R. O.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1911

8. AGE: Years 32 | Months 6 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name C A Livengood
13. Birthplace N.C.

MOTHER
14. Maiden Name Cath. Hokes
15. Birthplace N.C.

16 (a) Informant Harvey R O Plyler
(b) Address Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore Md

18 (a) Funeral director Geo. E. Talley
(b) Address Fulton & Fayette

19 (a) ... (Date rec'd by registrar) (b) Clayton Williams, Registrar

JUL 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1944 at 3 49 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1944 to 7/2 1944 and that I last saw her alive on 7/2 1944

Immediate cause of death Peripheral Circulatory Failure — Duration ...

Due to Paralytic Ileus — Duration 2 days

Due to ... — Duration ...

Other Conditions Post operative Cholecystectomy — Duration ...
(Include pregnancy within 3 months of death)

Date of operation 6/27

Major findings of operation: Chronic Cholecystitis & Cholelithiasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond Powell M. D.
Address Bon Secours Hosp Date signed 7/2/44

G 13670 ✓ G 13670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 577

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwards & Greene
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Geo
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Holt Bradford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mamie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-11-1892

8. AGE: Years	Months	Days	If less than one day
51	11	20	hr. min.

9. Birthplace Maryland (Town, county, and State)

10. Usual Occupation Lather & Plaster

11. Industry or business Plaster Work

FATHER
12. Name William R. Bradford
13. Birthplace Md.

MOTHER
14. Maiden Name Ida M. Thompson
15. Birthplace Md

16 (a) Informant Jesse Williams Bradford
(b) Address Laurel Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July-4-44 (month) (day) (year)
(c) Cemetery or crematory Savage
Location Savage Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md

19 (a) JUL 4 - 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1 1944, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1944, to 7/1 1944, and that I last saw h[illegible] alive on 7/1 1944.

Immediate cause of death Respiratory failure — Duration

Due to Brain tumor — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel, M.D. M. D.

Address Univ. Hospital Date signed 7/11/44

G 18671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G 18671 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution: Hebrew House for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 month
(e) Length of stay in Baltimore (yrs., mos., or days) 34Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Nusbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Moses Nusbaum
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Nusbaum
15. Birthplace Germany

16 (a) Informant Sylvan Nusbaum
(b) Address 4003 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) JUL 4 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22-1943, to 7-2-1944, and that I last saw h alive on 7-2-1944.

Immediate cause of death Paget's Disease — Duration 8-19-43
Chr. card. vascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin
Address Levindale Date signed 7/3/44

G 18672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 18672

Registered No. 168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 N Caster Street
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 N. Wash. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Beulah Finn (nee McDonald)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-2655

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Patrick Finn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1880

8. AGE: Years 63 | Months - | Days 5 | If less than one day hr. min.

64

9. Birthplace: Poplar Springs Md (Town, county, and state)

10. Usual Occupation: cook

11. Industry or business

FATHER
12. Name: James McDonald
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Frances Pool
15. Birthplace: Maryland

16 (a) Informant: Nancy Patterson (Century)
(b) Address: 6203 Eversall Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)
(c) Cemetery or crematory: Solemn M. E.
Location: Cedar Grove Maryland

18 (a) Funeral director: Charles E Schumunk
(b) Address: 2601 E Monument Street

(a) JUL 4 - 1944 (Date received by registrar) (b) Registrar: Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944, at 11 00 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Intra cranial Hemorrhage, Traumatic

Due to:

Other Conditions: Multiple lacerations of scalp.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-1-44 at 8.50 A.M.
(b) Where did injury occur? 816 N. Castle Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Blunt force

23. Signature: Howard J. Wheeler M.D. Medical Examiner.
Date signed 7-2-44

G 18673 ✓ G 18673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address [redacted]

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1431 S. Hanover St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hugh Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thelma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1898

8. AGE: Years 46 | Months -3- | Days 13 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Sworn-in weigher

11. Industry or business Fertilizer

FATHER

12. Name Harry

13. Birthplace Stuartstown, Penn.

MOTHER

14. Maiden Name Anna Hammer

15. Birthplace Stuartstown, Penn.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5. 44 (month) (day) (year)

(c) Cemetery or crematory Hopewell Lawn

Location Bayside Station Town

18 (a) Funeral director Chas J Powell

(b) Address 1417 Eastwood Ave

JUL 4 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1944; at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1944 to 7-3 1944, and that I last saw h[illegible] alive on 7-3 1944.

Immediate cause of death Coronary Thrombosis — Duration —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Hettrick

Address B.C.H. Date signed M 7 D 3/44

G 18674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G 18674 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5222 Beaufort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 18
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5222 Beaufort Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Cleveland Delcher, Sr.

3 (b) If veteran, name war: W.W. 1
3 (c) Social Security Account No. 705-05-7335

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or ~~wife~~: ~~XX~~ L. Marie Delcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1894

8. AGE: Years 49 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Inspector of Naval Material

11. Industry or business U.S.Navy

FATHER
12. Name John S. Delcher
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary C. Parks
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. L. Marie Delcher
(b) Address 5222 Beaufort Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) Date received by Registrar JUL 4 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1944, at 10.00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27 1944, to July 1 1944 and that I last saw him alive on 6/28 1944.

Immediate cause of death
1) Coronary Thrombosis — Duration 4 hrs.
Due to
Due to
Other Conditions - Congestion Pectoris — 4 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: - None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature - Earl L. Chambers
Address 4108 - Liberty Hts. Date signed M. 7 D. 3/44

[redacted] 18675 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937 Registered No. G 18675

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3224 Keswick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3224 Keswick Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Hollett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leah Hollett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1865

8. AGE: Years 78 | Months 8 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Conductor, Penna Railroad
11. Industry or business Retired

FATHER 12. Name Daniel Hollett
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Adams
15. Birthplace Unknown

16 (a) Informant Mrs. Leah Hollett
(b) Address 3224 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6-1944 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JUL 4 - 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3- 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to July 3 1944, and that I last saw him alive on July 3

Immediate cause of death Congestive Heart Failure — Duration
Due to Chr. Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Passmore M. D.
Address 4037 Falls Rd Date signed 7/3/44

G 18676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 18676 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (LENA) Lena Flaherty

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas
6 (c) If alive, give age 18[illegible] years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1872

8. AGE: ~~Years~~ 67 | Months 8 | Days 20 21 | If less than one day hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Charles Reicho
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mattery
(b) Address Nyork Pa

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 7/4/44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Cappy Pa

18 (a) Funeral director Milton Cook Inc
(b) Address 1219 E Saratoga St

19 (a) [illegible] (b) [illegible] Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1937, at 6:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Hemorrhage
due to Hypertensive C.V. Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/7/37

G 18672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Md
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution: Home for Aged Men
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 5 mo
(e) Length of stay in Baltimore (yrs., mos., or days) all his life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1400 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Friese
3 (b) If veteran, name war W
3 (c) Social Security Account No. none
4. Sex male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife MARGARET
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 11 1873
8. AGE: Years 71 Months 5 Days 21 If less than one day. hr. 22 min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Friese
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Stein
15. Birthplace Germ Balto Md

16 (a) Informant Supt
(b) Address 4 yrd Norman & Aged Mens Home
17 (a) Burial (b) Date thereof 7/6/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Philpott & Son
(b) Address 1217 St Paul St
19 (a) 4-1944 (b) Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944 at 7:40 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/19/42 19 to 7/3/44 19, and that I last saw him alive on 7/2/44 19

Immediate cause of death	Duration
Carcinoma of the stomach	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edwin C Jarrell M. D.
Address 11 E. Chase St Date signed 7/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18678 — BALTIMORE CITY HEALTH DEPARTMENT — G 18678 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alexander
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years: 74 | Months | Days | If less than one day: hr. min.

9. Birthplace: Frederick, Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER — 12. Name: David Knoth
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Francis Weaver
15. Birthplace: Md.

16 (a) Informant: Little Sisters of the Poor
(b) Address: 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 5, 1944 (month) (day) (year)
(c) Cemetery or crematory: St. Johns
Location: Frederick, Md

18 (a) Funeral director: Rita Wiedefeld
(b) Address: 914 Greenmount Ave

19 (a) (Date received by registrar) JUL 4 1944 Registrar: Huntington Williams, M.D.
VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 – 1944, to July 2 – 1944 and that I last saw her alive on July 1 – 1944.

Immediate cause of death — Duration

Edema of Lungs — 1 day
Due to: Chronic Myocarditis — 5 yrs
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: E Gill Hall
Address: 1631 E North Ave Date signed: 7/3/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR RECORDING

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD
information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
OCCUPATION is very important. See instructions on back of certificate.

1867S HEALTH DEPARTMENT—CITY OF BALTIMORE C1867S

CERTIFICATE OF DEATH ✓ 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 W Carrollton ave, 17 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

If U. S. Veteran specify WAR

2. FULL NAME Randie Robins Sydnor

(a) Residence: No. 303 W Carrollton ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Auburn Sydnor

6. DATE OF BIRTH (month, day, year) May 10, 1898

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	01	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Emmerton Va

FATHER

13. NAME Sam Veney

14. BIRTHPLACE (city or town) (State or country) Emmerton Va

MOTHER

15. MAIDEN NAME Susie Turner

16. BIRTHPLACE (city or town) (State or country) Emmerton Va

17. INFORMANT Rosa Sydnor sister

(Address) 669 W Pratt street

18. BURIAL, CREMATION, OR REMOVAL

Place Mulberry Cemetery Emmerton Richmond Co Va Date July 6 1944

19. UNDERTAKER Joseph A Sulz Funeral Home

(Address) 4699 Mont street Baltimore md

20. FILED JUL 4 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 7/1/44

22. I HEREBY CERTIFY, That I attended deceased from 6/20 1944 to 7/1/44 1944

I last saw h alive on 7/1/44 1944 Death is said to have occurred on the date stated above, at 4.45 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemmorhage	1 day 7/1/44
Arteriosclerosis	about 6 mos
Subacute Nephritis	

Other contributory causes of importance:

Was an operation performed? no Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John Barclay M. D.

(Address) 1718 W Carrollton ave

G 18680 G 18680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Johnny Cake Rd. or Country Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter S. Price, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 20 26

8. AGE: Years	Months	Days	If less than one day
19	1	12	hr. min.

9. Birthplace Phoenix, Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Walter S. Price
13. Birthplace Phoenix, Md.

MOTHER
14. Maiden Name Emma R. Boynton
15. Birthplace Phoenix, Md.

16 (a) Informant W. S. Price Sr.
(b) Address Johnny Cake Rd. Balto. Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove
Location Phoenix, Md.

18 (a) Funeral director Sandow M. Broyles
(b) Address Sparks, Md.

19 (a) 7-4-1944 (Date received by registrar) (b) Huntingtown Calvert Co. Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2-44 at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Cervical Vertebra

Due to

Other Conditions Trauma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-2-44 at between 10 & 10.30 A.M.
(b) Where did injury occur? Johnny Cake Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Thrown from horse

23. Signature Norman J. Waldeis M.D. Medical Examiner.
Date signed 7-2-44

G 19681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 19681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombardo Terrace
(c) Hospital or institution: Univ. of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 4
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Calvert
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Norman Locke

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 25 - 1910

8. AGE: Years: 33 | Months: 8 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Calvert Co (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name: James G Locke
13. Birthplace: md

MOTHER
14. Maiden Name: Isabell Brooks
15. Birthplace: md

16 (a) Informant: Isabell Locke
(b) Address: Appeal md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-6-44 (month) (day) (year)
(c) Cemetery or crematory: Eastern Chapel
Location: Calvert Co

18 (a) Funeral director: O. G. Lynch
(b) Address: Prince Frederick Md

19 (a) (Date rec'd by registrar) (b) Registrar

Filed JUL 4 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-3- 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944 to 7-3 1944 and that I last saw h.. alive on 7-3 1944.

Immediate cause of death: Toxemia — Duration:

Due to: Cellulitis of face

Due to: Streptococcic septicemia

Other Conditions: Rheumatic H.D. Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: F. M. Shipley M. D.
Address: [illegible] H. Date signed: 7/6/44

G 18682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 V

G 18682 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Randallstown (If outside city or town limits, write RURAL and give town)
(d) Street No. McCrook Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse M. Poole
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-4626
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/17/1908
8. AGE: Years 35 Months 7 Days 17 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Textile Worker
11. Industry or business
FATHER 12. Name Clarence Poole
13. Birthplace Maryland
MOTHER 14. Maiden Name Mary E Colston
15. Birthplace Maryland.
16 (a) Informant Elsie a Powders.
(b) Address Randallstown, Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8 1944 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md
18 (a) Funeral director H.C. Hinchcliffe
(b) Address Ellicott City, Md
19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1944, at 3:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1944 to 7/4 1944, and that I last saw him alive on 7/4 1944.

Immediate cause of death	Duration
Card. failure	
Due to Prob. gast. hemorrhage	
Due to Prob. gast ulcer.	
Other Conditions Prob. pulmonary TB	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. M. R. Crosby
Address Mercy Hosp. Date signed 7/5/44

JUL 5 1944

160

G 18683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G 18683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Hill Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Ackiss

3 (b) If veteran, name war —

3 (c) Social Security Account No. 210-05-5339

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beatrice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1905

8. AGE: Years 39 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business B. S Corp. Fairfield

FATHER
12. Name John F Ackiss
13. Birthplace N C

MOTHER
14. Maiden Name Mary Cook
15. Birthplace NC

16 (a) Informant Mrs Beatrice Ackiss
(b) Address 11 W Hall st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Brooklyn Md

18 (a) Funeral director William M Mareck
(b) Address 716 Light St

19 JUL 5 - 1944 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1-1944 at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Shock
Due to 1-2-3? Injuries burns

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-1-44 at 22/1 A M.
(b) Where did injury occur? 11 W. Hill St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Smoking Cigarette set fire to Mattress

23. Signature Howard J Wheeler M.D. Medical Examiner.
Date signed 7-2-44

18684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1612 G 18684
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore Brooklyn Pk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 W 11 Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Haynie Melvin J Haynie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) July 1, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Melvin J Haynie
13. Birthplace Va

MOTHER
14. Maiden Name Lula J Bellfield
15. Birthplace Va

16 (a) Informant Mrs. Melvin J Haynie
(b) Address 212 W 11 Ave Brooklyn Pk.

17 (a) Burial (b) Date thereof 7/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director William M Mareck
(b) Address 715 Light St

19 (a) (Date rec'd by registrar) (Registrar) Huntington Williams M.D.

JUL 5 VS 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 3 1944, and that I last saw he alive on July 3 1944.

Immediate cause of death	Duration
Interna gravis neonatorum	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Congenital Ureteral Ectopia bilateral

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Lubata M. D.
Address 1213 Light St. Date signed 7/4/44

G 18685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46f

Registered No. G 18685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING MARG

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 S.Eaton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 S.Eaton Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME JOHN ERMER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 216-09-4996

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Ermer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.5,1881

8. AGE: Years 62 | Months 7 8 | Days 25 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Coal Salesman

11. Industry or business J.W. Wolford & Son

FATHER
12. Name John Ermer
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Minnie Ermer
(b) Address 221 S.Eaton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-1944 (month) (day) (year)
(c) Cemetery or crematory ist.United Ev Cem
Location O'Donnell Street

18 (a) Funeral director Albert L. Wilt
(b) Address 1606 N.Chester Street

19 (Day) 6 (Month) 1944 (Year) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2/44 19 ... at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1944 to 7/2 1944 and that I last saw h. in alive on 6/30 1944

Immediate cause of death: Carcinoma of the Common Bile duct — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Thom

Address 321 J Eaton St. Date signed 7/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 18686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3125-Brendan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3125-Brendan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hamilton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife George W. Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29. 1877

8. AGE: Years 66 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Henderson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Bennett.
15. Birthplace Baltimore

16 (a) Informant George W. Hamilton
(b) Address 3125-Brendan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer-
Location Belair Rd.

18 (a) Funeral director Randell E. Humphreys-
(b) Address 1141 N. Broadway.

19 (a) Date received by registrar JUL 5 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1944 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944 to July 1 1944; that I last saw deceased alive on July 1 1944

Immediate cause of death Cardiac Failure — Duration

Due to Pneumonia

Due to

Other Conditions Cerebral hemorrhage 6 yrs ago.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.
Address 3706 Eastern Ave Date signed 7/3/44

over

G 18682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 18682 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. b
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 E Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Eisman

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-4894

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1877

8. AGE: Years 66 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Saloon

FATHER
12. Name Frank Eisman
13. Birthplace Russia

MOTHER
14. Maiden Name Rose P
15. Birthplace Russia

16 (a) Informant Mrs Bessie Eisman
(b) Address 2217 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/44 (month) (day) (year)
(c) Cemetery or crematory Holum Mt Carmel Cem
Location German Hall Road

18 (a) Funeral director Sol Levinson + Bros.
(b) Address 1124-26 W North ave

19 (a) (b) Registrar
(Filed by registrar)
JUL 5 - 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1944, to 7/4 1944, and that I last saw h[illegible] alive on 1. P. M. 1944 - 7/4

Immediate cause of death Cardio respiratory failure — Duration

Due to Pulmonary embolism

Due to Coronary sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary Embol. - Coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. Eisman
Address Sinai Hosp. Date signed 7/4/44 M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 18688

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY A. MACY

3 (b) If veteran, name war --
3 (c) Social Security Account No. 215-09-4251

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1875

8. AGE: Years 69 | Months 3 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace New York, N. Y.
(Town, county, and state)

10. Usual Occupation Fruit Auctioneer

11. Industry or business DeGeorgia Fruit Co.

FATHER
12. Name Sidney Macy
13. Birthplace Mass.

MOTHER
14. Maiden Name Emma Allison
15. Birthplace New York, N. Y.

16 (a) Informant Mrs. Margie Harned
(b) Address Wyckoff, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)
(c) Cemetery or ~~MEMORY~~ Cedar Grove
Location Queens, Long Island, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 5 - 1944
(Date rec'd by Registrar) Huntington Millspaugh, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to July 2 1944, and that I last saw him alive on July 2 1944.

	Duration
Immediate cause of death Sub Arachnoid Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7/3/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1226 G 18665 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Frederick Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gorman Hills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ralph Warren Hills
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1876

8. AGE: Years	Months	Days	If less than one day
68	4	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Arthur Pue Corman
13. Birthplace Maryland

MOTHER
14. Maiden Name Hattie Donegan
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6th 1944 (month) (day) (year)
(c) Cemetery Oak Hill
Location Washington, D. C.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

JUL 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944, to July 3 1944, and that I last saw h.C.R. alive on 19

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Paralytic ileus	
Due to Tuberculous peritonitis	
Other Conditions Tuberculous pleurisy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Paralytic ileus - Tuberculous peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Wardell M.D.
Address Union Memorial Hosp. Date signed 7-3-44

G 18690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94N Registered No. G 18690

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 Riggs Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 Riggs Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Ehrenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-1000

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Emma May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1889

8. AGE: Years	Months	Days	If less than one day
54	11	25	hr. min.

9. Birthplace Altoona, Pa. (Town, county, and state)

10. Usual Occupation Solicitor
11. Industry or business Balto. News

FATHER
12. Name John E. Ehrenfield
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary E. Grissinger
15. Birthplace Pa.

16 (a) Informant Mrs. Alva Ehrenfield
(b) Address 1928 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Carroll Co. Md.

18 (a) Funeral director Wm. J. Tuckwell & Son
(b) Address Balto. Md.

19 Date received JUL 5 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1944, at 6 50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 3 1944

G 18691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92d Registered No. G 18691

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4513 Sheenly Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur W. Harris.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-7995

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nina M. Harris

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec 18 1873

8. AGE: Years	Months	Days	If less than one day
70	6	15	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Polisher

11. Industry or business Black & Decker

FATHER
12. Name J. W. Harris.
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Derr.
15. Birthplace Maryland

16 (a) Informant Nina M. Harris
(b) Address 4513 Sheenly Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/44 (month) (day) (year)
(c) Cemetery or crematory Emory Chapel
Location Carroll Co Md

18 (a) Funeral director Ebenwald & Donovan
(b) Address 2615-17 Edmondson Ave.

19 (a) 7/5/44 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 8:15 A. M

21. I certify that I took charge of the remains described above, held an Inquiry - Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Myocardial Scarring
Due to Sarcoidosis Arteriosclerosis
Other Conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-4-44

G 18692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G 18692
Registered No.

MARK RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Redwood
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Bakerst
(If rural route, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L. Rohrbach.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wm H. Rohrbach

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct. 14. 1872

8. AGE: Years 71 | Months 8 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Henry Wolfe
13. Birthplace Penna.

MOTHER
14. Maiden Name Annie Beibe
15. Birthplace Germany

16 (a) Informant Wm.G.Rohrbach,
(b) Address 3004 Baker St.

17 (a) Burial (b) Date thereof July 6.1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co.Md.

18 (a) Funeral director Robert S.Little,
(b) Address 2700 Edmondson Ave.

19 (a) (b)
(Date received by registrar) (Registrar)

VS 1 JUL 5 - 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-44 19 ... at 8 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-44 19 ... to 7-3-44 19 ...; that I last saw her alive on 7-3-44

Immediate cause of death Coronary Thrombosis

Due to arterio-scler. C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Houston Flail M. D.
Address Univ. Hosp. Date signed 7-3-44

13693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18693 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Brody

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day hr.	min.
58				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Ida Brody
(b) Address 800 Greenmount Ave

17 (a) burial (b) Date thereof 7-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Workman Circle Cem.
Location Hebrew Mt. Carmel

18 (a) Funeral director Jace Levine Inc
(b) Address 1439 E. Baltimore St.

JUL 5 - 1944 Hampton Williams, M.D. Registrar
(Date rec'd by Registrar) (Signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 - 2 - 1944 at 8a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to 7-1 1944 and that I last saw him alive on July 1 1944

Immediate cause of death Acute coronary infarction — Duration

Due to Ch Coronary Sclerosis

Ch Hypertension

Due to Ch Myocarditis

Other Conditions Renal arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Homestead
Address 733 Ausgusta St Date signed M/D. 7/4/44

G 18634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered No. G 18634

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Frisby Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 54 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Frisby Street
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME James Louis Quinn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Stein
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1890

8. AGE: Years	Months	Days	If less than one day
About 54	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Purchasing Agent
11. Industry or business Penn. Water & Power Co

FATHER
12. Name William J. Quinn
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary N. Hagan
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. James L. Quinn
(b) Address 4100 Frisby Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meats and Son
(b) Address 805 N. Calvert Street

JUL 5 - 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1944 to July 3 1944, and that I last saw him alive on July 3 1944

Immediate cause of death	Duration
Acute Cardiac Embolism	1 Hours
Due to	
Due to	
Other Conditions Coronary Thrombosis Leg Amputated	8 yrs

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature John E. Hamer
Address 11 E. Chase St Date signed 7/6/44 M.D.

18695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 18695

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 Warashe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace Fortie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1879

8. AGE: Years 64 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Peter Washington

13. Birthplace S. C

14. Maiden Name Mina Clark

15. Birthplace Howard Co. Md

16 (a) Informant Hazel Green

(b) Address 736 Warashe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md

18 (a) Funeral director Charles S. Cooper

(b) Address 512 N. Carrollton Ave

JUL 5 - 1944 (Date rec'd by Registrar) Huntington Williams Md

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 1944 at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1944 to 6/30 1944.
and that I last saw h[illegible] alive on 6/29 1944

Immediate cause of death Acute Gangrene, Diabetes Mellitus, Sclerosis.

Duration: 3 years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Coon Allen Md Date signed 7/5/44

G 18656

18656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 W. Fayette St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Augustine Bena

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emile J. Bena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 | 24 | 1873

8. AGE: Years 71 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace France
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Boulanger
13. Birthplace France

MOTHER
14. Maiden Name Sebastine Simon
15. Birthplace France

16 (a) Informant Leon J. Bena
(b) Address 2613 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 | 7 | 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director J. A. Shipley & Son
(b) Address 320 Eastern Ave Huntingdon Station, Md.

19 (a) Date rec'd by Local Registrar JUL 5 - 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 | 3 | 1944 at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 | 15 | 1944 to 7 | 3 | 1944, and that I last saw h[illegible] alive on 7 | 3 | 1944.

Immediate cause of death	Terminal Failure	Duration
Due to	Arteriosclerotic C. V. D. with hypertension	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Healy M.D.
Address 71 - Bg. Hosp Date signed 7/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE [illegible] RESERVED FOR [illegible]

G 18692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144

Registered No. G 18692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Pulaski Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Leeds Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles E. Dailey

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Dailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/07

8. AGE: Years	Months	Days	If less than one day
36	7	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Westinghouse Electric
FATHER 12. Name Chas L Dailey
13. Birthplace Maryland
MOTHER 14. Maiden Name Margaret Riddle
15. Birthplace Md
16 (a) Informant Sarah Dailey
(b) Address 4404 Leeds Ave
17 (a) Burial (b) Date thereof July 6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director F. D. Kirkpatrick Son
(b) Address Baltimore Monroe St
19 (a) [illegible] 5-1944 Washington Hillsboro, Md.
(Filed) (Rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3/ 1944, at 2:19 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1944 to 7/3 1944 and that I last saw him alive on 6/2 1944.

Immediate cause of death: Acute Lymphatic Leukemia — Duration 2 Mos.
Due to —
Due to —
Other Conditions Hypertension, Bronchial Pneumonia
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas. Norton, Jr. M.D.
Address Bon Secours Hosp. Date signed 7/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

V8 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18635

54a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene Aves.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Sussex Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christine Owens

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1911

8. AGE: Years	Months	Days	If less than one day
32.	11	9	hr. min.

9. Birthplace Elkridge Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Charles Andrew Shadd (Sheats)
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emily Albert
15. Birthplace Balto., Md.

16 (a) Informant C. E. Owens
(b) Address 602 Sussex Rd. Towson Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory St Augustines Cem.
Location Catonsville Md

18 (a) Funeral director John Conway Son
(b) Address 901-03 Gallows St

19 (a) [illegible] (b) Huntington Williams, M.D.

JUL 5 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 5:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1944, to 7/3 1944, and that I last saw him alive on 7/2 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Brain Tumor	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/30/44
Major findings of operation: Ependymoma of 4th ventricle
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hosp. Date signed 7/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR RECORDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A3695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 Registered No. G 18636

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 James Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 James Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Silberzahn

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-7095

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1889.

8. AGE: Years	Months	Days	If less than one day
55.	5.	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation helper Sheet metal worker
11. Industry or business

FATHER
12. Name Charles W. Silberzahn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary A. Hissey
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Mary A Mouthley
(b) Address 1200 James Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 5 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Wedgewood Ave.

18 (a) Funeral director John F Brown & Son
(b) Address 1763 Hillen Street
(c) Washington Williams, M.D. Registrar
(Date rec'd by registrar) JUL 5 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1944 at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to July 2 1944.
and that I last saw h alive on July 2 1944.

Immediate cause of death
Pulmonary T.B.
Due to Tuberculosis
Due to Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
4 mos
5 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Richard Brown MD
Address (Date signed) 7/5/44

G 18700 | BALTIMORE CITY HEALTH DEPARTMENT | G 18700

CERTIFICATE OF DEATH 93d

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Maddox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert Maddox | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Brown
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 6 44 (month) (day) (year)
(c) Cemetery or crematory Payne's Cemetery
Location Washington D.C.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 5 1944 VS rec'd Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3- 1944, at 11:57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1944, to 7-3 1944, and that I last saw h alive on 7-3 1944.

Immediate cause of death Pulmonary edema — Duration 10 hrs
Due to Myocardial failure — 6 months
Due to Hypertension — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Cancun
Address 1401 Date signed 7-2-44 M.D.

G 18701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G 18701 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 E Baltimore St.
(c) Hospital or institution: ****************
(d) Length of stay in hospital or inst. (yrs., mos., or days) **** 20 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 E Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Underwood McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1332

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen D McDaniel (Stanley)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1905

8. AGE: Years 39 | Months **** | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Sheet Metal Repair Man

11. Industry or business Ship Yard.

FATHER
12. Name James U Mc Daniel
13. Birthplace Md

MOTHER
14. Maiden Name Ida Nelson
15. Birthplace md.

16 (a) Informant Helen D McDaniel (Wife)
(b) Address 3219 E Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44. (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery.
Location Eastern Ave Baltimore Md.

18 (a) Funeral director J. Melville Jenkins.
(b) Address 2713 Kirk Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUL 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 44 to July 2 19 44 and that I last saw him alive on July 2 19 44

Immediate cause of death: Diabetes — Duration: 1 yrs

Due to: arteriosclerosis

Due to: Cerebral Embolism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams, M.D. Physician

Date signed (7-5-44)

G 18702 ✓ G 18702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 E Wheeling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Wheeling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Zapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 23. 1872

8. AGE: Years 72 | Months | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Zapp
13. Birthplace Balto Md

MOTHER 14. Maiden Name annie Reinacher
15. Birthplace Balto. Md

16 (a) Informant Mrs. Margaret Zapp
(b) Address 13 E. Wheeling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Brooklyn Anne Co Md

18 (a) Funeral director Wm J Fleming
(b) Address 1426 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

JUL 6 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944 at 1.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to July 3 1944 and that I last saw h. alive on July 3 1944

Immediate cause of death Carcinoma of oesophagus

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L Miller M D

Address 1226 Clark St Date signed 7/5/44

G 18703 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G 18703 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 E. Heath St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Heath St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Harvell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: Dec. 29- 1893

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name George Harvell

13. Birthplace Germany

MOTHER — 14. Maiden Name Barbara Beck

15. Birthplace Germany.

16 (a) Informant Margaret (b) Address 5 E Heath St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer. Location Balto Md

18 (a) Funeral director Flynn & Fleming (b) Address 1426 Light St

(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944, at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1944 to July 2 1944 and that I last saw her alive on July 2 1944

Immediate cause of death: Carcinoma of the ovaries — Duration

Due to abdominal metastasis

Due to metastasis

Other Conditions metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Miller M D M. D.

Address 1125 N Charles St Date signed 7/5/44

Huntington Williams, M.D.

456624

BALTIMORE CITY HEALTH DEPARTMENT X 587 G 1876

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Lincoln Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elvey Grizzard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Russell

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 7-4-09

8. AGE: Years	Months	Days	If less than one day
35 34	-	-	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace S.C.

MOTHER
14. Maiden Name Frances Smith
15. Birthplace SC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Baltimore, Md.

18 (a) Funeral director D. L. Covington
(b) Address 21 W 25 St.

19 (a) Date received by registrar JUL 5 1944 (b) Registrar's No. 16 Huntington Hollins, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to July 4 1944 and that I last saw h[illegible] alive on July 4 1944.

Immediate cause of death: Respiratory failure — Duration

Due to: Pulmonary Edema

Due to: Rheumatic heart disease with acute rheumatic fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Duncan M. D.
Address 1 & H Date signed 7-4-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140 G 18705 Registered No.

MARG... RESERVED F... BE... ING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly, and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balt Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Leo St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Paul Koterwas or Antoni Katerwas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Koterwas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1885

8. AGE: Years 59 | Months 1 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Wagners Spt. Box Co

FATHER
12. Name Joseph Koterwas
13. Birthplace Poland

MOTHER
14. Maiden Name Frances
15. Birthplace Poland

16 (a) Informant Maryanna Koterwas
(b) Address 3726 Leo St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A A Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 15a JUL 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3 1944, at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944 to 7-3 1944 and that I last saw him alive on 7-3 1944

Immediate cause of death: Generalized cachexia — Duration

Due to: Clos. Cytophaga & Anaemia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature H Baer Jr MD.
Address McCulloh Balto. Md. Date signed 7-6-44 M. D.

G 19706 — X G 18706

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. H62

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write abbreviations. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Orchard Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. Main St. - Curtis Bay P. O. (If rural give location)
(e) Citizen of foreign country Balto. Co. Md. (Yes or No) If yes, name country

3 (a) FULL NAME Wm M. Gillece

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4985

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife (nee Duckett) Dorothy A. Gillece

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1915

8. AGE: Years 28 | Months 6 | Days 37 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Hardware Clerk

11. Industry or business Hardware

FATHER
12. Name Edw. B. Gillece, Sr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Timanus
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Dorothy A. Gillece
(b) Address Main St., Orchard Beach Md. (wife)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6, 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem. Location A. Arbo Md

18 (a) Funeral director A. Howard Evans
(b) Address 400-02 S. Charles St. Balto 30 Md.

19 (a) ____ (Date filed by registrar) (b) Huntington Williams, Md. Registrar

JUL 5 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3/44 19__, at 12 M P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 19 44, to 7/3 19 44, and that I last saw h[illegible] alive on 7/3 19 44.

Immediate cause of death	Duration
Cachexia	
Due to Metastatic Ca	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/19/43 (Colostomy)

Major findings of operation: Inoperable Ca of Sigmoid

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Traynor M. D.
Address Md. Gen'l Hosp. Date signed 7/3/44

G 18702

AB-87140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 18702 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 240 South Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Rychwalski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12- 1885

8. AGE: Years 59 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

19 JUL 5 - 1944 Huntington Williams M.D. (Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3- 1944, at 5.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1944 to 7-3 1944 and that I last saw h.i.m alive on 7-3 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: Hours

Due to: Hypertension — Duration: years

Due to: — Duration:

Other Conditions: Diabetes Mellitus — Duration: years

(Include pregnancy within 3 months of death)

Date of operation 3-24-44

Major findings of operation: Arteritis Gangrene Leg

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond M. Cunningham M.D.
Address Balto. City Hosp. Date signed 7-3-44

G 13703 Stella Lupa G 13703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1746 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hos
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Shakespeare St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanislawa (S. (Stella) Lupa

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-0011

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Casimir

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Goreaki
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Casimir Lupa
(b) Address 605 Shakespeare St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozaczuski
(b) Address 1930 Eastern Ave

19 (a) JUL 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944 at 1 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-F 1944 to 7-4 1944 and that I last saw h[illegible] alive on 7-4 1944

Immediate cause of death Congestive Heart Failure — Duration

Due to Hepatitis

Due to Cirrhosis Liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cirrhosis liver.

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Yagel Jr. M. D.
Address Bon Secours Hosp Date signed 7-4-44

G 13703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 13703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~[illegible]~~ 120 [illegible] location
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Slaughter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Earl Slaughter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1901

8. AGE: Years 43 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name [illegible] Brown
13. Birthplace "

MOTHER
14. Maiden Name [illegible] Brown
15. Birthplace "

16 (a) Informant Laura Smith
(b) Address 128 Calvin st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1090 Brantley ave

19 (a) JUL 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26- 1944 at 5:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Chronic Nephritis. Bronchial Pneumonia. Arteriosclerosis

(Exclude pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D. Medical Examiner.
Date signed 6-28-44

C 1871C

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

C 1871C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard A. Coates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Coates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1906

8. AGE: Years 37 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James A. Coates
13. Birthplace Md

MOTHER 14. Maiden Name Mary Owens
15. Birthplace Md

16 (a) Informant Mary Coates
(b) Address 818 W. Franklin St.

17 (a) Burial Burial, cremation, or removal (b) Date thereof July 5th 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Md

18 (a) Funeral director Elvey & Wilson
(b) Address 1000 Pennsylvania Ave

19 JUL 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Gun shot wounds of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/2/44 at 1:30 A. M.
(b) Where did injury occur? 5th Ward Jail
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? no
(d) Means of injury Fire arm

23. Signature Howard J. Weaden M.D. Medical Examiner.
Date signed 7-2-44

G 18711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G 18711

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where data are not known, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Waldo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3 (a) FULL NAME Matilda Wilkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Wilkins
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24 1843

8. AGE: Years 5 1 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Henrietta Wilkins
15. Birthplace md.

16 (a) Informant John Wilkins
(b) Address 1611 Waldo St.

17 (a) Pierce (b) Date thereof July 5th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Antietam PK
Location Columbus Cemetery

18 (a) Funeral director Percy O Wilson
(b) Address 1901 Brantley Ave

JUL 5 1944

19 (a) (Date rec'd by registrar) Huntington Williamson MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1944 at 12:33 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to July 2 1944, and that I last saw her alive on July 2 1944.

Immediate cause of death Bronchopneumonia — Duration 4 days
Due to Cardiac Decompensation
Due to Myocarditis
Other Conditions Nephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Legore M.D.
Address 822 N. Bond St Date signed 6/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 18712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 N Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Woods

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Caroline Woods
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1911

8. AGE: Years	Months	Days	If less than one day
33	2	28	hr. min.

9. Birthplace Mobile Ala
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Gas & Electric Co

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Caroline Woods (wife)
(b) Address 711 N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5th 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto.

18 (a) Funeral director Leroy O. Wilson
(b) Address 1600 Pennsylvania Ave

19 JUL 5 - 1944 (Date rec'd by local reg.) (a) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1944, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944, to July 1 1944, and that I last saw him alive on July 1 1944.

Immediate cause of death Chronic Nephritis (uremia) — Duration Uncertain

Due to

Due to

Other Conditions Mitral Insufficiency Marked Incontinence — Uncertain
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph E. Young
Address 1424 E Monument St Date signed 7/4/44

G 18713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G 18713 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3328 HUDSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 HUDSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W.HORNBERGER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced.: MARRIED

6 (b) Name of husband or wife: ELIZABETH HORNBERGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): SEPT.18 1890

8. AGE: Years: 53 | Months: 9 | Days: 14 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: RADIO REPAIRING

11. Industry or business: FOR SELF

FATHER
12. Name: LYSANDER HORNBERGER
13. Birthplace: BALTO.MD.

MOTHER
14. Maiden Name: JOHNANNA KYLE
15. Birthplace: BALTO.MD.

16 (a) Informant: ELIZABETH HORNBERGER(WIFE)
(b) Address: 3328 HUDSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 6/44 (month) (day) (year)
(c) Cemetery or crematory: SCHWARTZ CEM.
Location: ODONNELL ST.

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S.WOLFE ST.

(b) (Date received by Registrar) JULY 5 1944

Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 2 1944, at 9/30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944, to June 27 1944, and that I last saw him alive on June 27, 1944.

	Duration
Immediate cause of death: Auricular fibrillation	1 day
Due to: Arterio-sclerosis	?
Due to: Myocardial insufficiency	5 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: I. B. Bronushas, M.D.
Address: 3037 O'Donnell St Date signed: 7-5-44

G 13714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C Registered No. G 13714

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5303 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1901

8. AGE: Years	Months	Days	If less than one day
43	0	13	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Merchant Marine

FATHER
12. Name Herman Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Lippert
15. Birthplace Germany

16 (a) Informant Herman Baker
(b) Address 5303 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Colgate Balto Md

18 (a) Funeral director Lilly & Zeiler Co
(b) Address 1900 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 8 1944

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4-44, 1944, at 2 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebra

Due to

Other Conditions Both Femurs Fractured Hemorrhage, Lacerations, abrasions & bruises Body Burns

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-4-44 at 26/10 6:15 A M.
(b) Where did injury occur? Balto. & Highland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by Automobile

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 7-4-44

G 18715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13 1a

G 18715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 944 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 944 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Askins
3 (b) If veteran, name war None
3 (c) Social Security Account No. 212-12-6477
4. Sex Male
5. Color or race C
6 (a) Single, married, widowed, or divorced. Divorced
6 (b) Name of husband or wife Sarah Askins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 4 1892
8. AGE: Years 52 Months 10 Days 28 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Ck.
11. Industry or business

FATHER
12. Name Charles Askins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Askins
15. Birthplace

16 (a) Informant Viola Gibson Daughter
(b) Address 424 N. Eden St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location
18 (a) Funeral director Robert L. Cowan
(b) Address 8042 Carrington St. Huntington Williams, Md.
19 (a) (Date received by registrar) (b) Registrar

VS: JUL 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944, at 7:40 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to July 2 1944, and that I last saw h.im alive on June 30 1944.

Immediate cause of death	Duration
Cardio-Renal Hypertensive	unKnown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Bernard Harris M.D.
Address 1207 N Carrollton Ave Date July 3, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 19716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G 19716

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Ramsay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Wyatt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1885

8. AGE: Years 59 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Thomas Plummer
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Ball
15. Birthplace Md

16 (a) Informant Elmer E. Wyatt
(b) Address 1605 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry Hewitt & Co.
(b) Address 4816 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 5 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to July 3 1944 and that I last saw her alive on June 29 1944

Immediate cause of death: Carcinoma Stomach — Duration: 2 mo.

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury: —

23. Signature: O S Harding
Address 4801 Belair Rd Date signed July 5/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G 18717 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 W. Saratoga St
(If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard L. Briers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/2/1875

8. AGE: Years	Months	Days	If less than one day
69	3	1	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name John L. Briers
13. Birthplace England

MOTHER
14. Maiden Name Theresa Miller
15. Birthplace Balto Md

16 (a) Informant Theresa Briers
(b) Address 3106 W Saratoga St

17 (a) Burial (b) Date thereof 7/6/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto National
Location Frederick Ave

18 (a) Funeral director H. Wade
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151 JUL 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 44, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pyelonephritis and Chronic Hydronephrosis

Due to Prostatic Hypertrophy

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles J. Sobolinski M.D.
Medical Examiner.
Date signed 7/3/44

18718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V161a

G 18718
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W Mosher St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Jane Waller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			12 hr. 40 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Brother Thomas Waller
13. Birthplace Hodges, S. Carolina

MOTHER
14. Maiden name Jane Carlotte Thomas
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Jane Waller
(b) Address 1310 W Mosher St Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 5 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 5 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VE 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1944 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1944 to 6/21 1944, and that I last saw her alive on 6/21 1944.

Immediate cause of death	Duration
Atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within three months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B Dewese M. D.
Address 1310 W. Mosher St Date signed 7/1/44

1068

18719

AB-88768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

S-18719 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2113 Hollins St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural-give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Decker or Harry Frank Decker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 16- 1896
8. AGE: Years 48 | Months 5 | Days 14 | If less than one day hr. min.
9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business

FATHER
12. Name Charles Decker
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rose Stover
15. Birthplace Ohio

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8- 44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Jay O Hoy
(b) Address Baltimore Md

JUL 5 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3- 1944, at 1.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1944 to 7/3 1944 and that I last saw h alive on 7/3 1944

Immediate cause of death: Uremia; cardiac failure; terminal arteriosclerosis

Duration: 6 wks.

Due to: HCVD; interstitial nephrosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Lerman M.D.
Address BCH Date signed 7/5

G 18720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V13B

G 18720

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 5
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City of Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Low St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD WILLIAMS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-43

8. AGE: Years	Months	Days	If less than one day
0	10	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Russell Williams
13. Birthplace Port Huron, Mich

MOTHER
14. Maiden Name Mertis Williams
15. Birthplace Roxboro N.C.

16 (a) Informant Sydenham Hosp records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof July 5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location

18 (a) Funeral director Mrs Robert Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 (a) (b) Livingston Williams M.D.

JUL 5 1944
VS 1so

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3 1944, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944, to 7-3 1944 and that I last saw h. alive on 7-3 1944

Immediate cause of death: Miliary Tuberculosis — Duration: 2 mo

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Miliary tbc

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed

G 18721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 18721

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADABLE INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Ridge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) (Correction by Reg.)
If yes, name country

3 (a) FULL NAME Joan [redacted] Kalick

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Infant.

6 (b) Name of husband or wife NONE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 1943

8. AGE: Years	Months	Days	If less than one day
	10	3	hr. min.

9. Birthplace Philadelphia (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Joseph Kalick
13. Birthplace Philadelphia

MOTHER
14. Maiden Name Bessie Sylick
15. Birthplace Beccaria Pa

16 (a) Informant Mrs Joseph Kalick
(b) Address 3311 Ridge Ave, Phila.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)

(c) Cemetery or crematory
Location Philadelphia Pa.

18 (a) Funeral director Thomas W Dugleton
(b) Address Glen Burnie, Md.

19 (a) (Date filed by registrar) (Signature) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944 at 5:25 P M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute influential pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 5, 1944

G 19722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G 19722 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 S.Conkling St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 S.Conkling St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Laukeman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.29,1868

8. AGE: Years	Months	Days	If less than one day
75	7	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Not known
13. Birthplace " " "

MOTHER
14. Maiden Name " " "
15. Birthplace " " "

16 (a) Informant William Laukeman
(b) Address 1104 S.Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (Date received) JUL 5 1944 (Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2/1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1944 to 7/1 1944, and that I last saw h[illegible] alive on 6/29 19 44.

Immediate cause of death	Duration
(a) Coronary Sclerosis	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 32[illegible] Eastern Ave Date signed 7/5/44

Downes G 15723

G 15723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Goodwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Goodwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Homer Downes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1888

8. AGE: Years 56 | Months - | Days 2 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Guard State Hospital

11. Industry or business

FATHER
12. Name Oliver C. Downes
13. Birthplace Dover Del.

MOTHER
14. Maiden Name Anna B Seward
15. Birthplace Dover Del

16 (a) Informant Mrs Bertha E. Mayer
(b) Address 2703 Goodwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Leonard J. Rucks
(b) Address 5505 Harford Rd.

19 (a) Date received JUL 5 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944, to July 3 1944, and that I last saw him alive on July 1 1944.

Immediate cause of death: Carcinoma ? Stomach. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Boyle M. D.
Address 5217 Harford Rd. Date signed 7/4/44

C 18725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 18725

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Unionville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Nora Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Raymond Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name George Lough
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Nora Young
(b) Address Unionville, Md.

17 (a) Burial (b) Date thereof July 8. 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rocky Hill
Location Near Woodsboro, Md

18 (a) Funeral director D. D. Shaffer & Son
(b) Address New Windsor (Union Bridge) Md

19 JUL 6 - 1944 (b) Huntington Williamsport, Md.
(Date rec'd by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6.30 1944 to 7.5 1944, and that I last saw h. alive on 7.5 1944.

Immediate cause of death Respiratory Arrest — Duration

Due to Peritonitis

Due to Appendicitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6.30.44

Major findings of operation: Ruptured Appendix & Generalized Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Rinehart M. D.
Address University Hosp. Date signed 7.5.44

18725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 52a

Registered No. G 18725

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wynan Park Driveway and 31st S
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mo6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4mo6da

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town S. Mary's
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Brussels Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANLEY WILLIAM LONG

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Thalia Williams
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 5/15/02

8. AGE: Years	Months	Days	If less than one day
42	1	20	hr. min.

9. Birthplace Vandergrift, Pa.
(Town, county, and state)
10. Usual Occupation Asst. Engineer
11. Industry or business US Public Health Service

FATHER
12. Name Earl Long
13. Birthplace Indiana County, Indiana

MOTHER
14. Maiden Name Ellen M. Lydick
15. Birthplace Indiana County, Indiana

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)
(c) Cemetery or crematory Indiana Pa.
Location

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Indiana Pa.

JUL 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1944, at 12:10 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29, 1944, to July 5, 1944, and that I last saw him alive on July 5, 1944

Immediate cause of death	Duration
Squamous cell carcinoma of left renal pelvis with	2 years
Due to generalized metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/2/44
Major findings of operation: Cecostomy
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emerson Y. Gladhill M.D.
Address US Marine Hospital Baltimore, Md. Date signed 7/6/44

G 18726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 139 ✓

G 18726 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 West Fayette
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5½ hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Greenbelt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 M. Laurel Hill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Marbury Forbes Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: White.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-44. (4 AM)

8. AGE: Years | Months | Days | If less than one day: 5 hr. 30 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Marbury Forbes.
13. Birthplace Macon Ga.

MOTHER
14. Maiden Name Mary Lou Glover
15. Birthplace Little Rock, Arkansas

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Rogers Mk

18 (a) Funeral director Geo G Farley
(b) Address Fairfield & Forestville

19. JUL 6 - 1944 (Date rec'd by registrar) Clinton Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4- 1944 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1944 to 7-4 1944 and that I last saw him alive on 7-4 1944

Immediate cause of death

Duration

Due to Atel E Fetus

Due to (Premature 30 wk)

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Vogel, Jr. M. D.
Address B'N Sec Hosp Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 19722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 19722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Penna Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) ~~County~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Penna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1896

8. AGE: Years 48 | Months 2 | Days — | If less than one day hr. min.

9. Birthplace Buckingham Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Edward Johnson
(b) Address 726 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co. Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

19 JUL 6 - 1944 (Date rec'd by local reg.) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944 at 2:20 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1944 to July 3 1944 and that I last saw her alive on July 2 1944
Immediate cause of death

	Duration
Cerebral Hemorrhage	
Due to Hypertension and	
Due to Cardio Vascular Dis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. F. Howell
Address 600 N Carrollton Ave Date signed 7/6/44

G 19728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1061

G 19728 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2040 Hollins st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 Hollins st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Iris R. Vincent

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17th 1926

8. AGE: Years 18 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name Richard F. Vincent
13. Birthplace Md

MOTHER: 14. Maiden Name Ruth T. Moerken
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Ruth T. Vincent
(b) Address 2040 Hollins st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport

JUL 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4th 1944, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to July 1944, and that I last saw h[illegible] alive on June 28 1944.

Immediate cause of death: Chronic Bronchiectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Pound M. D.
Address 406 N. Bayson Date signed 7/5/44

G 18729 ✓ G 18729

JL - 88637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2902 E. Monument St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Tschudy

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Victor (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1871

8. AGE: Years 73 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Goffrey Swengeberg
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Mahna
15. Birthplace Germany

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St.

19 (a) JUL 6 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1944 at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1944 to 7/4 1944 and that I last saw her alive on 7/4 1944

Immediate cause of death	Duration
Congestive heart failure; lung edema; terminal coma.	2d.
Due to ASCVD; arteriolar nephrosclerosis	
Due to	
Other conditions diabetes mellitus; obesity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Was autopsy performed? Were findings considered in determining cause of death?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman M.D.

Address 4940 E. Eastern Ave. Date signed 7/5

1930 ✓ G 1930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 Whitridge Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Whitridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Gosnell

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~deceased~~ Sinclair B. Gosnell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30th 1901

8. AGE: Years 42 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace North Dakota (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Isaac Laisure
13. Birthplace Missouri

MOTHER
14. Maiden Name Edith Gemmill
15. Birthplace Md.

16 (a) Informant Mrs Laisure
(b) Address 429 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-44 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem Co.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1226 Pennsylvania Ave Baltimore, Md.

19 (a) JUL 26th 1944 (b)
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4th 1944, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1944 to July 4 1944 and that I last saw ~~him~~ her alive on July 2 1944

Immediate cause of death: Carcinoma of Cervix — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Mayo
Address 1331 E. 34th Ave Date signed 7-5-44 (M. D.)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 18731 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 E. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Agnes Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3, 1900

8. AGE: Years	Months	Days	If less than one day
43	8	2	hr. min.

9. Birthplace Cambridge Md. (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Charles Cephas

13. Birthplace Md.

MOTHER 14. Maiden Name Bessie Fort

15. Birthplace Md.

16 (a) Informant Ida Hopkins

(b) Address 1422 E. Monument St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 7/44 (month) (day) (year)

(c) Cemetery or crematory

Location Cambridge Maryland

18 (a) Funeral director Mr. Robert A. Elvis & Sons

(b) Address 1129 N. Caroline St.

19 (Date) July 7 1944 Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5- 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3- 1944 to 7-6- 1944, and that I last saw h[illegible] alive on 7-3- 1944.

Immediate cause of death Bronchio-Pneumonia — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Matt. Cargill M. D.

Address 611 N. Caroline Date signed 7-6-44

G 18732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

G 18732 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Carrollton Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Carrollton Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Joseph Jones
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1884

8. AGE: Years	Months	Days	If less than one day
59	11	3	hr. min.

9. Birthplace Fredericksburg, Va. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Parker
13. Birthplace Va.

MOTHER
14. Maiden Name Lou Washington
15. Birthplace Va.

16 (a) Informant Laura Jones Saunders daughter
(b) Address 411 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 (a) JUL 6 - 1944 (Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentress M.D.
Medical Examiner.
Date signed July 5, 1944

Howard Pinkard M.D.

G 15735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 15735

Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 Irving Place
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Irving Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ethel Nelson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Roger
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1902

8. AGE: Years	Months	Days	If less than one day
42	5	14	____ hr. ____ min.

9. Birthplace Frostburg, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Thomas W. Lewis
13. Birthplace Pa

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Pa

16 (a) Informant Roger Nelson
(b) Address 12 Irving Place

17 (a) burial removal (b) Date thereof 7/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Porter Cem.
Location Frostburg, Md.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address 22 & Ann Sts.

19 (a) JUL 6 1944 (Date rec'd by registrar) (b) Huntington [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 7 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentress M.D.
Medical Examiner.
Date signed July 5, 1944

G 18734 ✓ G 18734 ?

G 18[illegible]--88733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 W

Registered No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Hundley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April ? 1904

8. AGE: Years	Months	Days	If less than one day
40 ?	? 3	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jimmie Hundley (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Minnie ? (d)
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 7-6-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial P.K.
Location Balto. Maryland
18 (a) Funeral director Archibald A. Keighley
(b) Address 2101 McCulloh St.
19 (a) [illegible] (b) Huntingtown, Md.
Registrar

JUL 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1944, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27 1944 to 7/3 1944 and that I last saw h[illegible] alive on 7/3 1944.

Immediate cause of death	Duration
Uremia	3
Due to HCVD, arteriolar nephrosclerosis	
Due to	
Other Conditions Old M. Pemphigus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy Card. hypertrophy, as above; Fatty infiltration of liver, kidneys, [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Levinson M. D.
Address BCH Date signed 7/4/44

G 13735 ✓ G 13735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83W

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 McCulloh St
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 McCulloh
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Lydia Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1869

8. AGE: Years	Months	Days	If less than one day
55	6	7	..... hr. ..... min.

9. Birthplace Columbia S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business ✓

FATHER
12. Name John Casey.
13. Birthplace Columbia S.C.

MOTHER
14. Maiden Name Fanny Williams
15. Birthplace Columbia S.C.

16 (a) Informant Lena Bell
(b) Address 564 Baker St

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 7-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Md.

18 (a) Funeral director Archibald G. Gaddy
(b) Address 401 N. Mc Culloh St Williamsport, Md.

19 (a) ~~JUL 6 1944~~ (Date received) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to July 2 1944, and that I last saw her alive on July 2 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Dr. Hartman Higgins M. D.
Address 2243 Madison Ave Date signed July 6 1944

G 15736 ✓ G 15736

BALTIMORE CITY HEALTH DEPARTMENT 83a Registered No. 3698

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Calhoun St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Daisy Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George Roberts

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 20 1896

8. AGE: Years 48 | Months - | Days 14 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business House work

FATHER
12. Name Robert Russ
13. Birthplace Va

MOTHER
14. Maiden Name Martha Norris
15. Birthplace Va

16 (a) Informant Estella Thompson
(b) Address 1114 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/44 (month) (day) (year)
(c) Cemetery or crematory Lancaster Co
Location Virginia

18 (a) Funeral director Geo. H. Kelsay
(b) Address 1303 Pennsylvania Ave

19 (a) JUL 6 1944 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4- 1944, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3- 1944, to 7-4 1944, and that I last saw her alive on 7-4- 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 2 days

Due to: Hypertension + arteriosclerosis — Unknown

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M.D.
Address 1029 N. Stricker St Date signed 7-6-44

G 15727 V G 15727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 S. Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Goeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Geo. F. Goeller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 1860

8. AGE: Years 84 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name Goeller

13. Birthplace Germany

14. Maiden Name Ant. Jondro

15. Birthplace Germany

16 (a) Informant George F. Goeller

(b) Address 219 N. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Gilbert Rd.

18 (a) Funeral director Jos. E. Hillman

(b) Address 3 W. Lexington St. Baltimore Md.

19 (a) JUL 6 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4th 1944, at 3:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to July 4 1944, and that I last saw h-r alive on July 1 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Senility

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Mannon, M. D.

Address 3325 Eastern Ave. Date signed 7/5/44

1873 B

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered No. G 1573

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D. O. A. West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Hanover Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife Sarah Tucker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1897

8. AGE: Years 46 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Tucker
13. Birthplace Va.

MOTHER
14. Maiden Name Ella R. Hayes
15. Birthplace Md.

16 (a) Informant Mrs. Charles W. Fouratus
(b) Address 5211 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Maly's
Location Govanden

18 (a) Funeral director Edmonds & Donovan
(b) Address 3645 Eastern

19 (a) JUL 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury

23. Signature Clinton J. Sutherland M.D. Medical Examiner.
Date signed 7/12/44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 18783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G 18783 Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 E.Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E.Lanvale St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James L.Boarman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Lula E.Love
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.17,1878

8. AGE: Years	Months	Days	If less than one day
65	7	18	hr. min.

9. Birthplace Chestnut Hill Md.
(Town, county, and state)
10. Usual Occupation pipe fitter retired
11. Industry or business

FATHER
12. Name James L.
13. Birthplace Chestnut Hill Md.

MOTHER
14. Maiden Name Mary Grafton
15. Birthplace Chestnut Hill Md.

16 (a) Informant Mrs.Ertha Clow
(b) Address 1730 E.Lanvale St.

17 (a) Burial (b) Date thereof 7/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Deer Creek
Location Harford Co.Md.

18 (a) Funeral director Clarence F.Hoffmann
Address 1639 N.Broadway

19 (a) JUL 6 1944 Huntington Williams Mtz
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 7/4 1944
and that I last saw h. alive on 7/4 1944

Immediate cause of death

	Duration
Arteriosclerotic heart disease	10 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Mary Boarman
Address 1501 N. Milton Date signed 7/6/44

18740 AB-79368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G 18740

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 5mos-18days

(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1117 Haubert St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Alexander Miejdak or Alexander Meizdak

3 (b) If veteran, name war: Polish War Veteran

3 (c) Social Security Account No. 217-05-8262

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Francis ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5- 1874

8. AGE: Years 70 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER: 12. Name Ignaz Miejdak or Meizdak

13. Birthplace Poland

MOTHER: 14. Maiden Name Victoria Malanski

15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 9/44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary

Location Baltimore

18 (a) Funeral director Fred W Ozarzuski

(b) Address 1930 Eastern Ave.

19 Date received by Local Registrar JUL 6 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4- 1944, at 10.30M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/4 1944 and that I last saw him alive on 7/4 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 13 hr.

Due to HCVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. F. Bergman, M.D.

Address MCH Date signed 7/5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G 38721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address President Hosp 1514 Division St
(c) Hospital or institution: Wtk
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Race St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Nichols

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robt. Nichols

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 7-24-1870

8. AGE: Years 74 Months Days If less than one day hr. min.

9. Birthplace Southampton Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name Charles Blow

13. Birthplace Va

14. Maiden Name Henrietta

15. Birthplace Va

16 (a) Informant Robert Nichols

(b) Address 1141 Race

17 (a) Removal (b) Date thereof 7/8/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Waverly Va

18 (a) Funeral director Isaiah L. Brannon Sr

(b) Address 1052 W Montgomery St

19 JUL 6 - 1944 (Date rec'd by registrar) (b) Hunter's Ford Williamson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/44 19 ..., at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1944 to 7/5 1944 and that I last saw her alive on 7/4/1944

Immediate cause of death: Cerebral Hemorrhage — Duration 1 day

Due to: Hypertensive

Due to:

Other Conditions: Infected appendix and bed sore left.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard Moore M. D.

Address 1134 Harlem Ave Date signed 7/6/44

(OVER)

18752 LENNIE G 18752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 E Pratt St
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Lennie Charles Barber

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 7, 1913

8. AGE: Years	Months	Days	If less than one day
31	3	26	..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Shipyard

FATHER
12. Name William Barber
13. Birthplace Va

MOTHER
14. Maiden Name Lizzie Barber
15. Birthplace Va.

16 (a) Informant Lennie Barber (N)
(b) Address 1606 E Pratt St

17 (a) Burial (b) Date thereof 7/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaiah T. Brown & Son
(b) Address 10 E. W. Montgomery St

19 (a) JUL 6 - 1944 (b) Thurlington for Mitchell M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 12:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound
of neck
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 2 1944 2 P.M.
(b) Where did injury occur 17 S. Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury shot

23. Signature Robert L. Gutman M.D.
Medical Examiner.
Date signed July 3rd 1944

G 18743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18743

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glenndale (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Wise Avenue (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Gordon Bauge

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-1084

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertha Bauge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 - 1901

8. AGE: Years	Months	Days	If less than one day
43	5	2	....hr. ....min.

9. Birthplace Union Bridge, Frederick Co. Md (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Arbt Weld Mfg.

FATHER
12. Name Henry H. Bauge
13. Birthplace Maryland

MOTHER
14. Maiden Name Nellie Snyder
15. Birthplace Maryland

16 (a) Informant Henry H Bauge
(b) Address Union Bridge, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 - 1944 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek Cem.
Location Union Bridge Md

18 (a) Funeral director D. D. Hafer & Sons
(b) Address Union Bridge, Md

19 (a) Filed July 6 - 1944 (b) Registered by Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 4 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intra-cranial Hemorrhage, Traumatic

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 4, 1944 10 27 A M
(b) Where did injury occur? Corner Conk Oakley Roads
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Pedestrian struck by auto
23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed July 6, 1944

G 18745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1938 Registered No. G 18745

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5418 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 5418 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isabelle Bohn

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Bohn

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1874

8. AGE: Years: 69 | Months: 7 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER: 12. Name: Samuel C. Koch
13. Birthplace: Germany

MOTHER: 14. Maiden Name: Margaret ?
15. Birthplace: Germany

16 (a) Informant: Charles Bohn
(b) Address: 5418 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons INC. Co.
(b) Address: North Ave, & Broadway

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

JUL 6 1944

150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944 at 11. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to July 4 1944 and that I last saw h Er alive on July 4 1944

Immediate cause of death: Coronary Thrombosis — Duration: 1 day.

Due to: Hypertension, cardiac vascular disease — 10 yrs

Due to: Cerebral Hemorrhage — 8 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Herbert F. Kellman M. D.

Address: 6 E. Biddle St Date signed 7/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3/25'62
G 18745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Fauntleroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	married

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 87

8. AGE: Years	Months	Days	If less than one day
57	56		hr. min.

9. Birthplace VA. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Planter Fauntleroy
13. Birthplace VA

MOTHER
14. Maiden Name Louise
15. Birthplace VA

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brentley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 6 - 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944 at 4.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1944 to 7/2 1944
and that I last saw him alive on 7/1 1944

Immediate cause of death: Carcinoma of the Lung — Duration: 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Clark Knight M.D.
Address Johns Hopkins Date signed 7/4/44

JL - 88853 G 18746 BALTIMORE CITY HEALTH DEPARTMENT G-[illegible]
CERTIFICATE OF DEATH 6 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr. 40 Min
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Short Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Berkeley or James Berkeley
3 (b) If veteran, name war
3 (c) Social Security Account No. ?
4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Rosilee
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 17, 1905
8. AGE: Years 39 Months 4 Days 17 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Electric Welder
11. Industry or business

MOTHER / FATHER
12. Name John Berkeley
13. Birthplace Virginia
14. Maiden Name Annie ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/44 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond Va
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave
19 JUL 6 - 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4/44 19 at 6:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 7/4/44 19 to 7/4 19 44, and that I last saw h alive on 19

Immediate cause of death: Hemorrhage coronal Thrombosis — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Hettrick M. D.
Address B. C. H. Date signed 7/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167 G 18757

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1069 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Sturdevant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1921

8. AGE: Years 22 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Wadesboro N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Sturdevant
13. Birthplace N.C.

MOTHER
14. Maiden Name Minnie Pinewood
15. Birthplace N.C.

16 (a) Informant Minnie Sturdevant
(b) Address 2007 Llewellyn ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brand Lafayette

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/1/44 at 10 P. M.
(b) Where did injury occur? 1069 N. Gay Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-2-44

G 1743 — G 1743 — Registered No.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Wheeling Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Marks

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish Am. —	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1876

8. AGE: Years	Months	Days	If less than one day
67	8	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER — 12. Name	William Marks.
FATHER — 13. Birthplace	Unknown
MOTHER — 14. Maiden Name	Anna "
MOTHER — 15. Birthplace	"

16 (a) Informant Geo. J. Marshall
(b) Address 304 Martingale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Catonsville

18 (a) Funeral director Wm Col Jno
(b) Address 1317 N Paul St

19 (a) JUL 6 (Date rec'd by registrar) (b) 1944 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5- 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractures Contusions & bruised brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-2-44 at 23/2 1.15 A M.
(b) Where did injury occur? Charles & Wheeling Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by Street Car

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 7-6-44

VS 151

G 19749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 19749 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hannah Scherer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1866

8. AGE: Years 77 | Months 9 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bernard Graff
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Winter
15. Birthplace Germany

16 (a) Informant Lulu J. Petzold
(b) Address 905 Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) JUL 6 - 1944 (Date rec'd by registrar) Burial Permit Number Hutchinson Funeral Home

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6- 1944, at 7 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellenis M.D. Medical Examiner.
Date signed 7-6-44

G 18750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

200a

G 18750

Registered No. (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 Taplow Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Taplow Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Agnes Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John F. Hopkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3rd 1895

8. AGE: Years	Months	Days	If less than one day
48	7	2	hr. min.

9. Birthplace Des Moines Iowa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name E. E. Korwin
13. Birthplace Tuxedo Park N. Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant J. Irick Hopkins
(b) Address 107 Taplow Rd.

17 (a) Removal (b) Date thereof 7-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Monnetown N.Y.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUL 6 - 1944 (Registrar)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1944, at 6:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to July 5 1944, and that I last saw h[illegible] alive on 19...

Immediate cause of death Was dead on arrival Thyroid Tymored by Dr. W. E. Fisher.

Due to Sudden heart failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gibson Porter M. D.
Address 4822 Roland Ave Date signed

Approved by Howard J. Thomas M.D.

G 18751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G 18751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address B. & O. R.R.
(c) Hospital or institution: Mt. Clare Shops
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S. Smallwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIVA E. PENNINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-6157

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Daniel E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1906

8. AGE: Years	Months	Days	If less than one day
38	2 3	30 27	hr. min.

9. Birthplace Cass, West Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business B. & O. R.R.

FATHER
12. Name Warick Simmons
13. Birthplace Cass, W. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Daniel E. Pennington
(b) Address 530 S. Smallwood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9. 1944 (month) (day) (year)
(c) Cemetery or crematory Cass W Va
Location Cass W Va

18 (a) Funeral director Hall & B. M. Walter
(b) Address Pratt & Stricker Sts

19 (a) JUL 6 - 1944 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 7-6-44

18752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C 18752

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Sidney ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. Md (Westport) (If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Sidney ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) **FULL NAME** Louella H. Surran

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Samuel D Surran

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 20-1885

8. AGE: Years 58 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Morriston N. J. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Maurice Donnelly.
13. Birthplace N. J.

MOTHER
14. Maiden Name Josephine Henderson
15. Birthplace N. J.

16 (a) Informant Mrs. Samuel Surran
(b) Address 2224 Sidney ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 512 Hollins St

19 JUL 6-1944 Date rec'd by Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to July 5 1944, and that I last saw h.e.r alive on July 5 1944.

Immediate cause of death Coronary Thrombosis — Duration 48 hrs.

Due to —

Due to —

Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis J. Krock M. D.

Address 100 E. 23rd St Date signed 7/6/44

G 19758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G 19758

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give locality)
(d) Street No. 924 E. Conkling St (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sanders

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Katherine Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16-1869

8. AGE: Years	Months	Days	If less than one day
75	4	18/19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Frank Sanders
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Frank Sanders
(b) Address 924 E. Conkling

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 8 44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Henry Lord
(b) Address 2024 Orleans St

19 (a) JUL 6 1944 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 10 49 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull, multiple fracture of ribs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/9
(a) Date of injury July 5, 1944 8:35 A M.
(b) Where did injury occur? Eastern Ave + Highland St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by truck driven by Dudley

23. Signature Robert A. Fortune M.D. Medical Examiner.
Date signed July 5, 1944

G 18754

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

571 L

G 18754 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1025 W. 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Abecasis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-44

8. AGE: Years | Months | Days | If less than one day: 6 hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name William Abecasis
13. Birthplace New York, N.Y.

MOTHER
14. Maiden Name Hettie Weinstein
15. Birthplace Baltimore

16 (a) Informant Hettie Abecasis
(b) Address 1025 W. 36 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-44 (month) (day) (year)
(c) Cemetery or crematory Wash Rd
Location Wash Rd

18 (a) Funeral director Jack Levin
(b) Address 1439 E. Baltimore St.

19 (a) Date received by local registrar 7-6-1944 (b) Registered by Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Premature Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Premature

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond B. Hellberg M.D.
Address Sinai Hosp. Date signed 7/6/44

G 18755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 18755

Registered No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lofblad

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 - 1902

8. AGE: Years	Months	Days	If less than one day
41	9 10	2	hr. min.

9. Birthplace Baltimore Md
(City, county, and state)

10. Usual Occupation Investigator

11. Industry or business United Seamans Service

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Elva Wrightson

15. Birthplace Md

16 (a) Informant Rhonda,

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial Baltimore National thereof 7-8-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Frederick Ave

18 (a) Funeral director Woodall & Humphreys

(b) Address 4644 York Rd.

19 (a) (b)
(Date rec'd by Registrar) Registrar

JUL 6 - 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 12 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 1944 to 7-5 1944 and that I last saw him alive on 7-5 1944

Immediate cause of death
Myocardial Infarction
Due to Angina & coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Geneen

Address JHH Date signed 7-5-44 M. D.

G 18756

AB-88802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

G 18756 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 West Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Herion

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20-1876

8. AGE: Years 68 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Conrad Herion
13. Birthplace Germany

MOTHER: 14. Maiden Name Katherine Ross
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Charles Kochanskas
(b) Address 637 Washington Blvd.

19 (a) (b) Registrar
JUL 6 1944
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4- 1944, at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1944, to 7-4 1944, and that I last saw him alive on 7-4 1944.

Immediate cause of death: Uremia — Duration 5 days

Due to Hydronephrosis — Duration ?

Due to Ca. Prostate Obstruction ? — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 7-5-44

G 18757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 18757

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BOOKING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave + John St
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Hollon Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "A" Evans

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife mother Mrs Irena Mae Evans

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) July 5, 1944

8. AGE: Years	Months	Days	If less than one day
1day 0	0	1	23 hr. 11 min.

9. Birthplace Woman's Hosp. Balto, md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Mr. Edward Howard Evans Jr
13. Birthplace Virginia

MOTHER
14. Maiden Name Miss Irena Mae Coffin
15. Birthplace Bay Springs, Nebraska

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 3:49 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944, to July 6 1944, and that I last saw her alive on July 6 1944.

Immediate cause of death Respiratory failure — Duration

Due to Premature infant

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Evans
Address Woman's Hosp Date signed 7/6/44 M. D.

VS 8

1069

G 18758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 18758

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 S. Kossuth St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 S. Kossuth St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frederick J. Jacobus

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Katherine Jacobus
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/15/1854

8. AGE: Years	Months	Days	If less than one day
90	4	20	..... hr. ..... min.

9. Birthplace Germany
(Town, county and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Michael Jacobus
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte Hammelmann
15. Birthplace Germany

16 (a) Informant Mrs. Edgar F. Zollner
(b) Address 26 S. Kossuth St

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof July 7/44
(month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. S. Thompert Son
(b) Address 300 Eutaw Place

JUL 6 - 1944
(Date rec'd by registrar)
(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1944, at 4.0 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1944 to July 5 1944.
and that I last saw h[illegible] alive on July 4 1944

Immediate cause of death
Arteriosclerotic heart disease — Duration .....
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. McCleane M.D.
M. D.
Address 3321 Frederick Ave Date signed 7-5-44

G 18755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 18755

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4304 N. Greenway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Greenway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia Mackintosh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 1856

8. AGE: Years	Months	Days	If less than one day
88	1	6	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Mackintosh
13. Birthplace Scotland

MOTHER
14. Maiden Name Isabella Smith
15. Birthplace Balto Md

16 (a) Informant Helen Dunbar Small
(b) Address 4304 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co.
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 11-17 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to July 6 1944, and that I last saw her alive on July 6 1944.

Immediate cause of death: Ulcerated Enteritis
Due to Coma
Due to Pleural Effusion
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
72 hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Gibson Porter M. D.
Address 4822 Roland Ave Date signed

(over)

G 1876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G 1876

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 6 weeks

12-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Arlington (If outside city or town limits; write RURAL and give town)
(d) Street No. 1112 N. Edgewood Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH MARIE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Vicella Cunningham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1. 1873

8. AGE: Years	Months	Days	If less than one day
70	10	5	hr. min.

9. Birthplace Way, Virginia (Town, county, and state)
10. Usual Occupation Act. Asst. Surgeon
11. Industry or business

FATHER
12. Name Fielding Brown
13. Birthplace VA

MOTHER
14. Maiden Name Mary E. Sandige
15. Birthplace Virginia

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/6/44 (month) (day) (year)
(c) Cemetery or crematory
Location Arlington Va

18 (a) Funeral director William J. Tuckner & Son
Address Penn Avenue & Pennsylvania Ave
(b) Washington, D.C.

19 JUL 7 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1944 at 2:20p M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to July 6 1944, and that I last saw him alive on July 6, 1944.

Immediate cause of death: Carcinoma of pancreas with multiple metastases throughout abdomen — Duration 6mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address US Marine Hospital, Baltimore, Md. Date signed 7/6/44 M.D.

18761 ✓ G 18761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 E. 41st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 E. 41st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith Blades

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William M. Blades

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar 21, 1868

8. AGE: Years 76 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Seaford, Del (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name John H. Marvel
13. Birthplace Del

MOTHER
14. Maiden Name Ellen Hurley
15. Birthplace Md.

16 (a) Informant: Katherine Hearne
(b) Address 727 E. 41 St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 7 1944 (month) (day) (year)
9:00 Am
(c) Cemetery or crematory Seaford
Location Delaware

18 (a) Funeral director: Mrs. Mrs. John M. Pinfet & Son
(b) Address 801 N. Fayette St

JUL 7 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944, to July 5 1944, and that I last saw her alive on July 5 1944.

Immediate cause of death Myocarditis
7 nephritis

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Date signed 7-6-44

G 18762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G 18762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Henrietta B. Morton

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female — 5. Color or race: Colored — 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James L. Morton — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER — 12. Name Pendleton Wright

13. Birthplace Va

MOTHER — 14. Maiden Name Jane Taylor

15. Birthplace Va

16 (a) Informant James L. Morton

(b) Address 1013 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7th 44 (month) (day) (year)

(c) Cemetery or crematory Lincoln Cemetery

Location Maryland

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Bradley Ave

19 JUL 7 - 1944 (Date rec'd by registrar) Huntingtown Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944 July 4 1944 and that I last saw her alive on July 4 1944

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. S. Harvell M.D.

Address Date signed 7/6/44

~~18763~~ BALTIMORE CITY HEALTH DEPARTMENT ✓ G 18763

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Maryland. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Maryland. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald J. Chambers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th, 1944

8. AGE: Years	Months	Days	If less than one day
		1	10 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Clarence B. Chambers
13. Birthplace Va

MOTHER 14. Maiden Name Leora B. White
15. Birthplace V. Va

16 (a) Informant Mrs. White
(b) Address 2121 Maryland. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JUL 7 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to July 6 1944, and that I last saw him alive on July 6 1944

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Isador Hourfeld M.D.
Address 601 N. Monroe St Date signed 7/6/44

G 18764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 18764

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 E. 20 St. (Rooms)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Amperato

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 99

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28- 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walders M.D.
Medical Examiner.
Date signed 6-28-44

1070

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNIVERSITY MEDICAL SCHOOL JUL 6 1944

Commissioner of Health

JUL 7 1944

G 18765 ✓ G 18765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 N. Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D. 2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name of)
(d) Street No. 1102 N. Parrish St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Sidney J. Miles ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 yrs. | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Charles Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business —

FATHER
12. Name Henry Miles
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Katie Dent
15. Birthplace St. Marys Co. Md.

16 (a) Informant Annie Miles
(b) Address 1102 Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Arlington Ave Huntington Hotel

19 (a) JUL 7 1944 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944 to 7-5 1944 and that I last saw him alive on 7-5 1944

Immediate cause of death Lobar Pneumonia — Duration 7 Days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. N. Pigott M. D.
Address 1136 W. Lanvale St. Date signed 7-6-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

950 Registered No. G 18766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Frank Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-2525

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Clerk

FATHER
12. Name Joseph Sachs
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Sykes
15. Birthplace Russia

16 (a) Informant Mae Sachs
(b) Address 2614 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 Date rec'd by Local Reg. JUL 7 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 9.50

20. DATE OF DEATH July 6, 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-15 1943 to July-4 1944 and that I last saw alive on July 4 44.

	Duration
Immediate cause of death: Cerebral embolism	
Due to: Rheumatic heart disease	7 Y.
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond H Culver M. D.
Address 5611 Rumbers Rd Date signed 7-6-44
Culver

G 18767 ✓ G 18767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital Baltimore General 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Race St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. (S)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elvis Butts
(b) Address 1105 Race St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co. Md

18 (a) Funeral director Isaiah L. Brown & Co
(b) Address 108 W Montgomery St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 15 JUL 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1944, at 12 M U.O.P.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 5 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

G 19738

TN. 87914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Goode

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1886

8. AGE: Years 57 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Prince Edward Good
13. Birthplace British West Indies

MOTHER
14. Maiden Name Charlotte Hopkins
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location Baltimore Md

18 (a) Funeral director Sarah C Brennan
(b) Address 1086 Montgomery Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form JUL 7 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH June 17, 1944 19 at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1944, to 6-17 19 44
and that I last saw h. alive on 6-17 19 44

Immediate cause of death: Pulmonary Tuberculosis — Duration: Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mattman M.D.
Address B. C. H. Date signed 6/25/44

G 19769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G 19769 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Division Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond L. Watkins

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-03-6155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1910

8. AGE: Years	Months	Days	If less than one day
34	3	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace

MOTHER
14. Maiden Name Ethel Watkins
15. Birthplace Md.

16 (a) Informant Agnes Watkins
(b) Address 1424 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) JUL 7 - 1944 (Date rec'd by registrar) (b) Huntington Md.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5- 1944, at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen, followed by acute peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-3- at 11:45 A M.
(b) Where did injury occur? 1220 Division Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire-arm - revolver

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 7-6-44

T.G.P.-86902 G 1377D

G 1377D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where information is not known, write "Unknown." Do not use abbreviations. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mo. 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

15-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Presstman Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Toyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1894

8. AGE: Years 49 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Jerry Johnson (d)
13. Birthplace Virginia

MOTHER: 14. Maiden Name Addie Carter (d)
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. B. Kelson
(b) Address 1732 Presstman St

19 (a) JUL 7 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 5, 1944, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1944 to 7/5 1944, and that I last saw h alive on 7/5 1944

Immediate cause of death: Coronar Occlusion; Hypostemia — Duration: 2

Due to: HCVD; Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.

Address BCH Date signed 7/5

Huntington Williams, M.D.

G 1577 X ✓ G 1577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
516

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Just came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pleasant Hill Park.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Mitzel.
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-07-9789

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Marie B. Mitzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1885

8. AGE: Years	Months	Days	If less than one day
58	9	2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name J. F. Mitzel
13. Birthplace Md.

MOTHER
14. Maiden Name Fanny Montgomery
15. Birthplace Md.

16 (a) Informant Wife - Marie Mitzel
(b) Address Owings Mills, Md.

17 (a) Burial (b) Date thereof July 8, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Deer Park
Location Reisterstown

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown

19 (a) (Date received by registrar) (b) Reisterstown, Md.

VS 15 JUL 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1944 to 7/5 1944
and that I last saw h[illegible] alive on 7/5 1944

Immediate cause of death Cerebral accident — Duration 2 hrs.

Due to Metas. Lung & L.H. of Prostate.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Jane D. Coy M.D.
Address Mercy Hosp. Date signed 7/5/44

G 18772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/3B

G 18772 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Cambridge St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Cambridge Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Jaskulski (Or) Shriver

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-7710

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Rosalie Jaskulski
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 31, 1894

8. AGE: Years	Months	Days	If less than one day
49 50	11	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Serviceman
11. Industry or business Continental Can Co Inc

FATHER
12. Name Walenty Jaskulski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Borkowski
15. Birthplace Poland

16 (a) Informant Mrs. Rosalia Jaskulski
(b) Address 2202 Cambridge Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) (Date rec'd by registrar) (b)

JUL 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1944, at 6.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944, to July 5 1944, and that I last saw him alive on July 5 1944.

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis	3 m 4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mario A. Iannarelli M.D.
Address 1705 E. Balt. St Date signed July 5th 1944

G 19773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178

G 19773 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Hampstead 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia A. Ebehart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife John Ebehart

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1877

8. AGE: Years 66 | Months 8 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name George Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Lucabaugh
15. Birthplace Md.

16 (a) Informant Mr. John Ebehart
(b) Address Hampstead

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Stultzes Cem.
Location Stultzes, Pa.

18 (a) Funeral director Edward Tipton
(b) Address Hampstead, Md.

19 (a) JUL 7 - 1944 (Registrar's signature) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1944, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1944 to 7-6 1944, and that I last saw h[illegible] alive on 7-6 1944.

Immediate cause of death ..... Duration
Respiratory Crand
Due to (over)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Rinehart M. D.
Address University Hosp. Date signed 7-6-44

G 19774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 19774 162 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR H...DING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wallbrook + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wallbrook + Caton Aves. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Louise Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/27/59

8. AGE: Years 85 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Roxbury, Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Golan
15. Birthplace Ireland

16 (a) Informant St. Agnes Hospital
(b) Address Caton + Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 N. North Ave.

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D.

JUL 7 1944

VS-186

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/6 19 44 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 19 44 to 7/6 19 44 and that I last saw h... alive on 7/6 19 44

Immediate cause of death Cardiac failure — Duration

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryson
Address St. Agnes Hosp. Date signed 7/6/44

G 13775

G 13775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 8-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2331 Echodale St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William Ruppert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Lena Ruppert

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1864

8. AGE: Years 80 Months 4 Days 15 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Beth Steel

FATHER
12. Name Don't know
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace Germany

16 (a) Informant Henry Ruppert
(b) Address 2331 E Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto

18 (a) Funeral director Wm H Sigmund Sons
(b) Address 2004-8 Aliceanna St

19 (a) JUL 7 - 1944 (Date rec'd by registrar) (b) Registrar

VS 3

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 6 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1944 to 7-6 1944 and that I last saw him alive on 7-6 1944.

Immediate cause of death Bilateral Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions generalized arteriosclerosis Urinary retention-ca 20 yr

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn B. Schreiber M. D.
Address 54 S. Fulton Ave. Date signed 7-7-44

G 18776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1943

G 18776

Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1143 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 N. Carey St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Martha Thompson Jones
3 (b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mr. Robert Jones
6 (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) Nov 28 1885
8. AGE: Years 58 Months 7 Days 5 If less than one day ___ hr. ___ min.
9. Birthplace Richmond Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own home

FATHER
12. Name John Thompson
13. Birthplace Virginia

MOTHER
14. Maiden Name Sophia Newman
15. Birthplace Va

16 (a) Informant Charles Jones
(b) Address 1143 N. Carey St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore, Md.
18 (a) Funeral director Mr. George H. Hafland
(b) Address 1631 Druid Hill Ave.
19 (a) Date received by Local Registrar 7-7-1944 (b) Huntington Wilkinson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3- 1943, at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 5-1-1944 to 7-3-1944, and that I last saw her alive on 7-2-1944

Immediate cause of death Myocarditis — Duration 1 yr.
Due to
Due to
Other Conditions Arterio sclerosis — Duration unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 7-4-44

G 10777

AB-77674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G 10777

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 9mos. 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 12
(c) City or town Baltimore (If outside city or town limits, write RUBAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gorak or Ludwik ~~Gorczak~~ GORCZAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Margaret (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 75			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Luke Gorak (D)
13. Birthplace Poland
14. Maiden Name Barbara ? (D)
15. Birthplace Poland

16 (a) Informant Joseph Nowak
(b) Address 820 S. milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) 1944 (Date rec'd by Registrar) (b) H. [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 11¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/5 1944 and that I last saw h[illegible] alive on 7/5 1944.

Immediate cause of death Ca of stomach — Duration

Due to

Due to

Other Conditions Gen. arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Bergman

Address BCH Date signed 7/6

G 13778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1943 D

Registered No. G 13778

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: 2101 Cold Spring Lane 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William Schultheis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER: 12. Name.....
13. Birthplace

MOTHER: 14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address.....

17 (a)..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL JUL 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 JUL 7 1944 (Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944, at 7 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 27, 1944

1080

G 19779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944 Registered No. G 19779

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1265 Savage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 6 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUL 7 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1944, at 6 30 PM

21. I certify that I took charge of the remains described above, held an Inspection-Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 6-30-44

F 1079

Grave #9

G 18780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G 18780

1. PLACE OF DEATH: Found East Falls ave + Lombard st.
(a) Baltimore City, Maryland
(b) Street address 700 Flact Street
(c) Hospital or institution:
Baltimore City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. D. A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown, White, Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 50? Months: Days: If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JUL 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (c) JUL 6 1944 (Date rec'd by registrar) (d) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1944, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at ? M.
(b) Where did injury occur? Jones Falls. East Falls ave + Somerset Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Found drowned.

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed June 19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 18781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 18781

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4730 Dunkirk Rd.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4730 Dunkirk Ave (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Lucy May Algire

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jno. Jacob Algire
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Jan 5 1874
8. AGE: Years: Abt-70 | Months: 6 | Days: 0 | If less than one day: hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: John W. Cannoles
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Christine Heigel
15. Birthplace: Baltimore

16 (a) Informant: Miss Carrie C. Algire daughter
(b) Address: 4730 Dunkirk Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8 44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md.

18 (a) Funeral director: Stuart Morgan Co.
(b) Address: 108 W North Ave.

19 (a) Filed [illegible] 19[illegible] (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 20 1944 to July 5 1944 and that I last saw h[illegible] alive on July 5 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 yrs
Due to: Hypertension — 10 yrs
Due to: Arterial Sclerosis
Other Conditions: Myocarditis — 5 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Chas A Carlson M. D.
Address: 2145 W Balto Date signed

G 10782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 875 W Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jamie Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June, 1899

8. AGE: Years	Months	Days	If less than one day
45	1		hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Louis Gregory
13. Birthplace Va.

MOTHER
14. Maiden Name Grace Jones
15. Birthplace Va.

16 (a) Informant William Jones
(b) Address 1921 Eldewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/44 (month) (day) (year)
(c) Cemetery or crematory Richmond
Location Virginia

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Park Ave

19 (a) 7-6-1944 (Date rec'd by registrar) (b) Signature of registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 44, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 19 44 to July 5 19 44, and that I last saw her alive on July 5 19 44.

Immediate cause of death: Pneumonia and failure
Due to: Bronchial Asthma
Due to:
Other Conditions: Pulmonary Edema
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: G. Burgess
Address Provident Hospital Date signed 7/6/44

G 18783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √95C

Registered No. G 18783

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 663 Vine St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward Mantiply

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lynchburg Va. (Town, county, and state)

10. Usual Occupation Preacher

11. Industry or business

FATHER 12. Name Edward Mantiply
13. Birthplace Va.

MOTHER 14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Edward J. Mantiply, Jr.
(b) Address 663 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director A. Halstead
(b) Address 907 Druid Hill Ave, Balto. Md.

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

JUL

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 4 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Cardiac hypertrophy & dilatation

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Fentress M.D. Medical Examiner.
Date signed July 5, 1944

VS 151

G 18784 ✓ G 18784

JO #86026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Beaver St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	3	19	18	86

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jeff Wilson
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Jimson
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7. 9. 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Q. Q. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1944, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1944 to 7/4 1944 and that I last saw alive on 7/4 1944.

Immediate cause of death Pulmonary TBC — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Leipman M. D.
Address BCH Date signed 7/5

G 18725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGINS RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3623 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3. (a) FULL NAME Delia Kyne

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — —

8. AGE: Years About 77 | Months ? | Days ? | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business —

FATHER
12. Name Michael Kyne
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hynes
15. Birthplace Ireland

16 (a) Informant Catherine Kyne
(b) Address 3623 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director H. U. Mears and Son
(b) Address 505 N. Calvert St.

19 JUL 7 - 1944 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1944, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 6 1944

G 18736 ✓ G 18736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 E. 29th St,
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Caroline Haske

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank Haske

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1864

8. AGE: Years 80 | Months 0 | Days 7 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Anthony Grieb
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Grieb
15. Birthplace Germany

16 (a) Informant Mrs Haske
(b) Address 1626 E 29th St

17 (a) Burial (b) Date thereof July 8th
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Edmund W. Carlin's Son
(b) Address 924 E. Eagle St.

19 (a) — Registrar

JUL 7 1944 Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1944, at 2 1/2 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5-1944 to 7-5-1944, and that I last saw her alive on 7-5-1944.

Immediate cause of death: Arteriosclerotic cardio renal disease — Duration: Minutes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theo B. Sybert M. D.

Address 802 Harford Rd Date signed 7-6-44

BALTIMORE CITY HEALTH DEPARTMENT X V G 18783
Registered No.

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Aisbeus Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Hazel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Schaffner
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 - 1944

8. AGE: Years	Months	Days	If less than one day
—	—	—	7 hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Edward Schaffner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Georgette Charlotte
15. Birthplace Balto., Md. Baecke

16 (a) Informant Mrs. Georgette Schaffner
(b) Address 211 Hazel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George L. Schmidt
(b) Address 2101 Pennsylvania Ave. Baltimore, Md.
(c) Date received JUL 7 - 1944 (Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7 1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1944 to 7-7 1944, and that I last saw h.[illegible] alive on 7-7 1944.

Immediate cause of death	Duration
Pre. Mature	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important. MARGIN RESERVED FOR BINDING

G 18788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

Registered No. G 18788

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Greene.
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 or W Washington Blvd (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ?

3 (a) FULL NAME Matthew Kilekowech (Kelly)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	widowed?

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John A. Grebiancfer Jr
(b) Address 423 S. Paca St.

19 (a) JUL 7 1944 (Date registered) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to July 5 1944, and that I last saw him alive on July 5 1944.

Immediate cause of death	Duration
Uremia	
Due to	
Due to	
Other Conditions Carcinoma of Rectum	

(Include pregnancy within 3 months of death)

Date of operation 6-6-44

Major findings of operation: Ca. of Rectum —

of autopsy: Same with adenoma of Prostate

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huhleman

Address Univ. Hosp. Date signed 7/5/44 M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 18783 ✓ G 18783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1226

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1638 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R. Bruscup

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Late George Bruscup
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1873.

8. AGE: Years 70 | Months 10. | Days 1 | If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER: 12. Name Henry Kamm
13. Birthplace Germany

MOTHER: 14. Maiden Name Anna Weberberger
15. Birthplace Germany

16 (a) Informant Mr. George Kamm
(b) Address 1721 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 1944. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Road

18 (a) Funeral director Harry A Whitzke
(b) Address 4101 Edmondson Ave.

19 JUL 7 - 1944 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5/44. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 19 44 to July 5 1944, and that I last saw her alive on July 5 1944

Immediate cause of death	Duration
Acute Myocarditis	10 days
Due to Arteriosclerosis	10 days
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 402 Edmondson Ave. Date signed 7/8/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

VS 150

G 18736 ✓ G 18736

BALTIMORE CITY HEALTH DEPARTMENT

Jo #88855

CERTIFICATE OF DEATH 937

Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs. 55 min.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6705 Bessemer Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Oberle

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	211-07-5051

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1899

8. AGE: Years	Months	Days	If less than one day
45	4	1	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation MACHINEST
11. Industry or business BETH. STEEL CO.

FATHER
12. Name ALBERT J. OBERLE
13. Birthplace PENNA.

MOTHER
14. Maiden Name KATHERINE ONEILL
15. Birthplace PENNA.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 8/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zecker Co.
(b) Address 403 S. WOLFE ST.

19 (a) Filed by registrar Washington Williams, MD Registrar
JUL 7 - 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1944, at 1:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1944 to 7/6 1944 and that I last saw h[illegible] alive on 7/6 1944.

Immediate cause of death	Duration
Cerebral hemorrhage prior to L. myocardial infarct, Acute Cerebral Hemorrhage	
Due to HTN V D	
Due to	
Other Conditions Ar. Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Dr. Moore

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Sergman
Address BCH Date signed M 7 D 6

G 19781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 19781

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or Institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. ROBINSON ST.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JOHN H. NEUBAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife LILLIE NEUBAUER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 23 1873

8. AGE: Years	Months	Days	If less than one day
70	11	6 13	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation BRIDGE CARPENTER
11. Industry or business B & O RR.

FATHER
12. Name MICHAEL NEUBAUER
13. Birthplace GERMANY

MOTHER
14. Maiden Name AUGUSTA SHOEMAKER
15. Birthplace GERMANY

16 (a) Informant LILLIE NEUBAUER (WIFE)
(b) Address 516 S. ROBINSON ST.

17 (a) BURIAL (b) Date thereof JULY 10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GREEN HAVEN
Location GLEN BERNIE MD.

18 (a) Funeral director Lilly & Zeck Chapel
(b) Address 403 S. WOLFE ST.

19 (a) 1944 (b) by Washington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1944, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1944 to 7-6 1944, and that I last saw h.i.m. alive on 7-6 1944

Immediate cause of death	Duration
Cardiogenic Shock	
Due to Myocardial Infarction	
Due to Arteriosclerotic and Hypertensive Cardiovascular Dis.	
Other Conditions Diabetes Mellitus Benign Hypertrophy of Prostate	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Ord. shows

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature W. D. Arnold M.D.
Address Sinai Hosp. Date signed 7-7-44
M. D.

City G. 1782 ✓ XG 1782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME George Daugherty

SS 218-10-7945

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23, 1900

8. AGE: Years	Months	Days	If less than one day
44		21	..... hr. ..... min.

9. Birthplace Crisfield, Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business .....

FATHER
12. Name Charles O. Dougherty
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Maggie F. Dize
15. Birthplace Somerset Co., Md.

16 (a) Informant Gordon Carlyle Dougherty
(b) Address Crisfield, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)
(c) Cemetery or crematory Crisfield
Location Crisfield, Md.

18. (a) Funeral director Lawson & Hubbard
(b) Address 306 Main St., Crisfield, Md.

19 (a) 6/14/44 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13 1944 at 5:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1944 to 6/13 1944 and that I last saw him alive on 6/12 1944

Immediate cause of death	Duration
Uraemia	24 hrs.
Due to Malignant Hypertension	6 mos.
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Martin E. Strobel M. D.
Address Univ. Hospital Date signed 6/13/44

MARG... RESERVED FOR B...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7 1944

G 13783 ✓ G 13783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Hillman Street
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Hillman Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Mast

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alfred R. Mast
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1858

8. AGE: Years	Months	Days	If less than one day
86	0	12	##hrrrff min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Sebastian Zang
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Edith Grimes (Daughter)
(b) Address: 1301 Hillman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 1944 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto; Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date received by registrar) (b) Registrar

JUL 7 - 1944
VS 1a

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th, 1944, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to July 2 1944 and that I last saw h[illegible] alive on July 2 1944.

Immediate cause of death: Acute Cardiac failure — Duration

Due to: Ch. General arteriosclerosis

Due to: —

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hometem

Address 733 Argyle St Date signed 7/7/44 (M. D.)

G 10734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Dr~~
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Baugher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 72 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Elkton, Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jos. L. H. Barker
13. Birthplace Elkton, Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Jos. Baugher Sr.
(b) Address 1634 Rickenbacker Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9-44 (month) (day) (year)
(c) Cemetery or crematory Maiden Cemetery
Location Elkton, Va.

18 (a) Funeral director Ellsworth, Arwood
(b) Address 3911 Liberty Hghts. Ave.

19 (a) 7-5 1944 (b) Huntington Williams M.D. (Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to Arteriosclerotic C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 7/5/44

G 15795 X ✓ G 15795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/3/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/3/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Bethlehem (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Tombler Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Seifert, Ralph Erwin

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If divorced, date

7. Birth date of deceased (mo., day, yr.) May 6, 1906

8. AGE: Years	Months	Days	If less than one day
38	1 11	11	hr. min.

9. Birthplace U. S. A. (Town, county, and state)
10. Usual Occupation Chief Steward Mate
11. Industry or business USN

MOTHER / FATHER
12. Name Unknown
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant U.S. Navy Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-44. (month) (day) (year)
(c) Cemetery or crematory
Location Bethlehem Pa.

18 (a) Funeral director J. Lee Odell
(b) Address 1644 York Rd.

19 (a) 7-8-1944 (Date rec'd by registrar) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1944, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3, 1944, to July 5, 1944, and that I last saw him alive on July 5, 1944

Immediate cause of death: Thrombosis of left middle cerebral artery and its primary branches with a resultant large area of degeneration and necrosis of the lt. cerebral hemisphere — Duration: 2 da.

Other Conditions marked toxic hepatitis myocarditis, spleenitis and nephritis

(If pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Ostrander
Address US Marine Hospital, Baltimore, Md. Date signed 7/8/44

18753 BUTLER V G 18736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B Registered No.

MARG... RESERVED FOR B...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 T
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Mae Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14th 1909

8. AGE: Years 34 Months 5 Days 21 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Charles Butler

13. Birthplace Maryland

MOTHER 14. Maiden Name Williams & Bowles

15. Birthplace Carolina Va, & Conn

16 (a) Informant Charles Butler

(b) Address 2816 Fort Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-8-44 (month) (day) (year)

(c) Cemetery or crematory Lot Mayfield

Location Balto, Maryland

18 (a) Funeral director Archibald E. Gaddis

(b) Address 2101 McCulloh St.

19 (a) 7-8-1944 (Date received by Registrar) (b) Huntington Hill, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 44 at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 19 44 to July 5 19 44 and that I last saw [illegible] alive on July 5 19 44.

Immediate cause of death Pulm. Tbc. — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Was autopsy?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.

Address 312 E 23rd St Date signed 7-5-44

G 18792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G 18792

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2451 Loretta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Elsie May Connelly

3 (b) If veteran, name war —— W
3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	Married

6 (b) Name of husband John F. Connelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22nd 1890

8. AGE: Years	Months	Days	If less than one day
53	8	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Tusa F. Benson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Poulton
15. Birthplace Balto. Md.

16 (a) Informant John F. Connelly
(b) Address 3000 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

JUL 8 - 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944 at 12 1/4 M
21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to July 7 1944 and that I last saw he/she alive on July 6 1944

Immediate cause of death: Pulmonary oedema — Duration: 3 days
Due to Carcinoma of Gall Bladder — 6 mos.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation May 12 1944
Major findings of operation: Carcinoma of Gall Bladder
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William E. Johnson, M.D.
Address 100 E 33rd St Baltimore Md Date signed 7/7/44

456307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G 19752

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard C. Lizer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Clara Lizer

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-5-84

8. AGE: Years 58 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation
11. Industry or business: Md Drydock

FATHER 12. Name: John Lizer
13. Birthplace: Md

MOTHER 14. Maiden Name: Alice Lizer
15. Birthplace: Md

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location: Dorsey, Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 JUL 8 - 1944 (b) Registered by: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944 at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to July 7 1944 and that I last saw him alive on July 7 1944.

Immediate cause of death	Duration
Carcinoma of lung right, & metastases	
Due to to pleura and	
Due to pleural effusion	
Other Conditions Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: not granted

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John R. Cunningham M.D.
Address: J H H Date signed 7/5

G 1933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 19233 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Do not write above or below a line. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette Bet Wolfe Sts

(c) Hospital or institution: Bon Secours

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and name of town)

(d) Street No. 331 S. Calhoun St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Louise M Gunther

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W'd.

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/1871

8. AGE: Years 72 Months 8 Days 24 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John F. Siegert

13. Birthplace Germany

MOTHER 14. Maiden Name Mary A. Mehrig

15. Birthplace Germany

16 (a) Informant Mrs. Margaret Vogel

(b) Address 1204 E. 33rd St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore Md

18 (a) Funeral director F. D. Shippert Sons

(b) Address 3601 Eastern Ave. Lauraville

19 (a) (Date received by registrar) JUL 8 - 1944 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 1944, at 9:00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/7 1944 to 7/7 1944 and that I last saw her alive on 7/7 1944

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerosis Cardio-Vascular Disease	
Due to	
Other Conditions Intestinal Obstruction (Include pregnancy within 3 months of death)	

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Raymond Boyer M.D.

Address 1 W Lexington St Baltimore Md Date signed 7/5/44

G 18800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G 18800

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Green Sts.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Balto
(c) City or town: Balto. (2)
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 763 W. Lexington ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Benjamin Verner

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.):
8. AGE: Years: 69 | Months: | Days: | If less than one day: hr. min.
9. Birthplace: Pa. (Town, county and State)
10. Usual Occupation: Glass Blower
11. Industry or business:

FATHER
12. Name: Andrew
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Mary Neely
15. Birthplace: Scotland

16 (a) Informant: Benjamin Verner
(b) Address: 763 W Lexington St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory:
Location: UNIVERSITY MEDICAL SCHOOL JUL 7 1944

18 (a) Funeral director: Commissioner of Health
(b) Address:

JUL 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1944, to 6-30 1944, and that I last saw him alive on 6-30 1944.

Immediate cause of death: Uremia — Duration:

Due to: Chronic Glomerulitis
Carcinoma ampulla recti

Due to: Syphilis
Pneumonia

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: 6-23-44
Major findings of operation: Carcinoma ampulla & Vesicle
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: M E Robertson M. D.
Address: Univ. Hosp. Date signed: 7-3-44

VS 150

F 1081

451319
D 18801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G [illegible] Registered No. 46a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N Montford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Mae Lutz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-90

8. AGE: Years 53 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John W. Stokes
13. Birthplace Md

MOTHER 14. Maiden Name Jenne Hollen
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore

18 (a) Funeral director Lula Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) [illegible] (b) [illegible]

JUL 8 1944 Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 3:32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 21 1944 to July 7 1944, and that I last saw h.C.R alive on July 7 1944.

I. Immediate cause of death Coronary Thrombosis & Arteriosclerosis — Duration

Due to

Due to

Other Conditions Salivary carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Flanders
Address Johns Hopkins Hospital Date signed 7/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 18962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G 18962

MARG... RESERVED FOR E...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Oswego Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Oswego Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM HENRY MARKEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1862

8. AGE: Years	Months	Days	If less than one day
81	11	12	hr. min.

9. Birthplace Bantlysville, Md. (Town, county, and state)
10. Usual Occupation Engineer - Retired
11. Industry or business B. & O. R. R.

FATHER
12. Name George Markey
13. Birthplace Md.

MOTHER
14. Maiden Name Clementine Cole
15. Birthplace Md.

16 (a) Informant Mrs. Margaret E. Markey
(b) Address 2301 Oswego Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 1 JUL 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1944, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944, to July 6 1944, and that I last saw him alive on July 5 1944.

Immediate cause of death	Duration
Myocarditis (a)	4 mos.
Tuberculosis (b)	
Due to	
Due to	
Other Conditions Bronchial asthma, Hodgkin's dis. anemia	mos/yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred R. St Barbin M. D.
Address 4723 Park Heights Ave Date signed 7/7/44

G 19303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 19303

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5419 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

27 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5419 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT L. TWEEDALE

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 213 - 10 - 3468

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Antoinette C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 18, 1892

8. AGE: Years 52 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Balmar Corp.

FATHER
12. Name John W. B. Tweedale
13. Birthplace Md.

MOTHER
14. Maiden Name Isabelle Barford
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Antoinette Tweedale
(b) Address 5419 Reisterstown Rd. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) JUL 8 1944 Huntington Williams Mgr. Registrar Address 11 E. Fayette St. Date signed July 8- 44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1944 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1944 to July 4th 1944 and that I last saw him alive on July 4th 44

Immediate cause of death: Tuberculosis enteritis
Due to Pulmonary T.B. Duration 1 yr
Due to Gastro Enterology. Bronchiectasis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. A. Lieser M. D.

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

456921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Pereen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Evelyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-12

8. AGE: Years 31 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ben Pereen

13. Birthplace N. C.

MOTHER 14. Maiden Name Martha Harrison

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 8/44 (month) (day) (year)

(c) Cemetery or crematory Location La Crosse Virginia

18 (a) Funeral director Mrs. Robert G. Ellett Sr.

(b) Address 1129 N. Caroline St.

19 (a) (b) Huntington Williams, M.D. Registrar

JUL 8 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1944 at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1944 to July 5 1944 and that I last saw h[illegible] alive on July 5 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Intercostal neuralgia	3 Wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graham Pereen

Address [illegible] Date signed 7-7

G 19305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 19305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Ave
(c) Hospital or institution Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits write RURAL and give town)
(d) Street No. 106 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha V. Shaw

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 3 - 1871

8. AGE: Years: 72 | Months: 8 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business:

MOTHER / FATHER

12. Name: George Hefer
13. Birthplace: Balto. Md.
14. Maiden Name: Mary Winnett
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Howard Eigner
(b) Address: 106 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 11-44 (month, day, year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: John J. Nolan
(b) Address: 3000 E. Balto. St.

19 (a) JUL 8 - 1944 (Date rec'd by registrar) Washington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944 to July 7 1944 and that I last saw her alive on June 6 1944

Immediate cause of death: Cerebral Hemorrage — Duration: 7/5/44
Due to:
Due to: Chr. Myocarditis — 1943
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Penrey Brown
Address 1663 W. North Ave Date signed M. D. 7/7/44

G 19906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 19906 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 East 23rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 East 23rd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE JONES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1873

8. AGE: Years	Months	Days	If less than one day
70	6	26	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edmond Wood
13. Birthplace Va.

MOTHER
14. Maiden Name Amanda ?
15. Birthplace Va.

16 (a) Informant Mrs Cora Jones
(b) Address 424 East 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JUL 8 1944 (Date filed with Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 6, '44 19 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1944 to July 6, 1944, and that I last saw h[illegible] alive on July 8 1944.

Immediate cause of death Coronary Thrombosis — Duration Suddenly

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marie Odom, M. D.
Address 312 E 23rd St Date signed 7-8-44

G18807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G18807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly given. Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Kwiatowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1056

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances Kwiatkowski

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 53 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Andrew Kwiatkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Sadek
15. Birthplace Poland

16 (a) Informant Frances Kwiatkowski
(b) Address 2615 Fleet Street

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-11-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2 S. Patterson Park

19 (a) JUL 8 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 19 44, at 12 30 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Sobieski M.D. Medical Examiner.
Date signed 7/7/44

VS 151

G18808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G18808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 N Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Bruce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Pearley Bruce

6 (c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Chester Va (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Moses Perkins
13. Birthplace Va

MOTHER
14. Maiden Name Molly Baldwin
15. Birthplace Va

16 (a) Informant Pearley Bruce Husband
(b) Address 1108 N Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elmer Wilson
(b) Address 1020 Bryant St

19 JUL 8 - 1944 (Date rec'd by registrar) (b) Huntington Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 5-45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943, to July 3 1944, and that I last saw h alive on July 2 1944.

Immediate cause of death Aortic Insufficiency — Duration 9 mos

Due to

Due to

Other Conditions Hypertension, Coronary Disease — Duration 9 mos
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L Young M. D.
Address 14 W Monument St Date signed 7/5/44

Krogh

G18809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G18809

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — BALDWIN WOOD
(b) Street address 2809 Barnwood ave
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town 2809 Barnwood ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Co. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Wilhelmina Elenor Krogh

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Amelia Krogh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1876

8. AGE: Years 68 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thomas Krogh
13. Birthplace Freder Co Md.

MOTHER
14. Maiden Name A. Catherine Warner
15. Birthplace Frederick Co Md

16 (a) Informant Mrs C R Lorey
(b) Address 2809 Barnwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/44 (month) (day) (year)
(c) Cemetery or crematory Taylorsville, Md
Location Taylorsville, Md

18 (a) Funeral director Otho S Dunkin
(b) Address Forest Park Md

19 (a) JUL 8 - 1944 (Date rec'd by registrar) (b) Herman Dayton Williamsport, Md

V8 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to July 6 1944, and that I last saw h[illegible] alive on July 6 1944.

Immediate cause of death: Coronary Occlusion — Duration 1 hour

Due to: Arterio-Sclerosis Generalized

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Herman Dayton M. D.
Address 20 E Preston Street Date signed 7/7/44

G18810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

Registered No. G18810

MARK RESERVED FOR RECORDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Medwood + Green 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 90
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Ringwalt (Katharine Hamilton Ringwalt)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, ~~married, widowed, or divorced~~: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1867

8. AGE: Years 77 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Retired Teacher
11. Industry or business Art School, Phila., Pa.

FATHER
12. Name John Lyther Ringwalt
13. Birthplace Penn.

MOTHER
14. Maiden Name Jessie Elder
15. Birthplace Penn.

16 (a) Informant Mrs. Ira Houghton
(b) Address 1719 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Mount Moriah, Location Phila., Pa.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 5 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1944 to 7/7 1944, and that I last saw h.e.r. alive on 7/7 1944.

Immediate cause of death	Duration
Cerebral accident	
Uremia + Diabetes Mellitus	
Due to	
Due to	
Other Conditions Dehydration + anemia	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Ramsey M. D.
Address Univ. Hosp. Date signed 7-7-44

G18811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160C

G18811 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Woodstock (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1944

8. AGE: Years | Months | Days | If less than one day: 19 hr. 55 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Marshall Bennett
13. Birthplace Woodstock, Maryland
14. Maiden Name Dorothy Gains
15. Birthplace Maryland

16 (a) Informant hospital records
(b) Address Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Druid Hill Ave

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) (Date received by Registrar) (b) Registrar

JUL 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 2.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1944, to July 8 1944, and that I last saw h[illegible] alive on July 8 1944.

Immediate cause of death	Duration
Intrauterine asphyxia	
Due to Premature	
Due to Ante partum Hemorrhage	
Due to Placenta Praevia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 7-44 (Cesarean)
Major findings of operation: Placenta Praevia
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stapleton Jr. M.D.
Address Johns Hopkins Hospital Date signed 7-8-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G18812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Mewirkirk
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Susie Adams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Chas. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Conway
13. Birthplace Virginia

MOTHER
14. Maiden Name Louisa Brewer
15. Birthplace Md.

16. (a) Informant Hospital Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)

(c) Cemetery or crematory Mumkirk Md.
Location

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis, Md.

19 (a) JUL 9 1944 (Date received by registrar) Washington Williams Md. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8 1944, at 9 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 19__, to 7-8 1944, and that I last saw her alive on 7-8 1944.

Immediate cause of death Respiratory Failure — Duration

Due to High Spinal anesthetic ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pt. not operated.

of autopsy: Not reported yet

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Palmatier M. D.

Address University Hospital Baltimore, Md. Date signed 7-8-44

MARGINAL RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18813

BALTIMORE CITY HEALTH DEPARTMENT ✓ G18813 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Tunbridge Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle A. Arbaugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edwin H. Arbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Louis Bopst
13. Birthplace Md.

MOTHER 14. Maiden Name not known
15. Birthplace

16 (a) Informant Edwin H. Arbaugh
(b) Address 629 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12. 1944 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem. Co.
Location Westminster Md.

18 (a) Funeral director N. Bankard & Son
(b) Address Westminster, Md.

19 (a) 1944 (Date rec'd by Registrar) (b) Clayton Mellor, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944, 1:25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/29 1944 to 7/9 1944, and that I last saw h. alive on 7/9 1944.

Immediate cause of death Cystic sarcoma of ovary

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers, M.D.
Address Md. Gen. Hosp. Date signed 7/10/44

G18814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18814
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Hartford Rd
(c) Hospital or institution: Hartford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Middlesex
(c) City or town Wake P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Emma Jane Stiff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Andrew W Stiff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-1856

8. AGE: Years 87 | Months 6 9 | Days 8 25 | If less than one day ... hr. ... min.

9. Birthplace Princess Anne Co Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name O M Walker
13. Birthplace Princess Anne Co, Va

MOTHER
14. Maiden Name B J Whitehurst
15. Birthplace Princess Anne Co Va

16 (a) Informant H Gordon Stiff
(b) Address 6023 Bellona Ave

17 (a) Removal (b) Date thereof 7/8/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hartfield Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 1416 Ames.

19 (a) Filed by registrar ... Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944 at 6 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to July 8 1944 and that I last saw h[illegible] alive on July 1 1944.

Immediate cause of death: Chronic Myocarditis — Duration: 8 years
Due to:
Due to:
Other Conditions: Arterio Sclerosis — 10 years
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 5106 Harford Rd Date signed 7-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18815 WITLER ✓ G18815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkens & Caton Aves.
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 8 Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna V. Witter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: William H Witter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1881

8. AGE: Years 63 | Months | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Patrick J Lynn

13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Mc Hale

15. Birthplace Ireland

16 (a) Informant Housekeeper

(b) Address

17 (a) Burial (b) Date thereof 7-11-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director J. J. Fahey & Son

(b) Address 18 Light St

19 (a) 9-1944 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7, 1944, at 7 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1[illegible] 1944 to 7/7 1944

and that I last saw her alive on 7/7 1944.

Immediate cause of death	Duration
Septicemia	
Due to Multiple fistula ano	
Due to Pneumonia	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sister Rafaela C.S.J. M. D.

Address St Agnes Hosp Signed 7/7/44

G18816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G18816 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624. N. Washington. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 N. Washington. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Catherine Voegelein.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7th 1861

8. AGE: Years	Months	Days	If less than one day
83	1		hr. min.

9. Birthplace Baltimore. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Francis Voegelein
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Edelman
15. Birthplace Germany

16 (a) Informant Mrs. Flora Jenkins.
(b) Address 1624. N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July.10 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N. Wolfe St

19 (a) Date received by July 9 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July. 7th. 1944 at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5th 1944 to July 7. 1944.
and that I last saw [illegible] alive on July 6 1944.

Immediate cause of death: Heat Exhaustion — Duration: 2 days
Due to
Due Chronic Myocarditis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 606 N. Bethany Blasdell [illegible]

G18817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G18817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2167½ N Exeter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 2167½ N Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Marble

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) [illegible] -1944

8. AGE: Years [illegible] Months Days If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Servant

11. Industry or business

FATHER 12. Name Robert Marble

13. Birthplace Wilson N.C.

MOTHER 14. Maiden Name Dora Patterson

15. Birthplace Balto Md

16 (a) Informant Mrs Dora Marble

(b) Address 2171 N Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Co Md

18 (a) Funeral director Brantingham & Hodges

(b) Address 72 Augusta St

19 (a) [illegible] (b) JUL 9 - 1944 Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944 at 11 45 PM

I certify that death occurred on the date above stated; that I attended deceased from June 29 1944 to July 6 1944 that I last saw him alive on June 30 1944

Immediate cause of death

(a) premature (Born the pregnancy)

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

Duration 7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. S. Gallagher

Address 12 E Augusta St Date signed July 9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physician: Please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

G18818
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 683 N. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Sumpter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1938

8. AGE: Years 6 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Tenny Sumpter
13. Birthplace S C

MOTHER
14. Maiden Name Carrie Mae Hall
15. Birthplace S C

16 (a) Informant Tenny Sumpter
(b) Address 348 Carey St

17 (a) Burial (b) Date thereof July 6 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carey
Location

18 (a) Funeral director A Hasty
(b) Address 9 [illegible]

19 (a) JUL 9 - 1944 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7-1944, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to

Other Conditions Enlarged Thymus & Mesenteric Glands.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 7-8-44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G18819 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1650 N. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1650 N. Gilmore St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Julia Virginia Jones
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles R Jones
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Sept 20 - 1881

8. AGE: Years 63 | Months 9 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Calvert Co Md (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Benjamin Kent
13. Birthplace Md

MOTHER 14. Maiden Name Rachel Mansell
15. Birthplace Md

16 (a) Informant Bertha Howe
(b) Address Prince Frederick Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 10 - 44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Calvert Co Md

18 (a) Funeral director Pindell & Sewell
(b) Address Prince Frederick Md

19 (a) [illegible] (Local registrar) (b) Huntingtown Williamsville Md JUL 9 1944

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to July 7 1944, and that I last saw h alive on July 7 1944.

Immediate cause of death Bronchopneumonia — Duration 2 days
Due to Cerebral Thrombosis — 2 weeks
Due to Arteriosclerosis
Other Conditions Hypertension — 10 yrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward L Reynolds
Address 822 N Bond St Date signed 7-9-44

G18820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G18820

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1218 Patapsco St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1218 Patapsco St
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary Booth

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George G. Booth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 25, 1910

8. AGE: Years 34 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace: Balto
(Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: Frank J. Meyers
13. Birthplace: Balto. Md

MOTHER
14. Maiden Name: Emma Hubbard
15. Birthplace: Md

16 (a) Informant: George G. Booth
(b) Address: 1218 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 11, 1944 (month) (day) (year)

(c) Cemetery or crematory: Leday Hill
Location: O. A. B.

18 (a) Funeral director: A. Kenard Evans

(b) Address: 1400 W. Lombard St

19. (a) [illegible] (b) Huntington, Md
(Filled by registrar) Registrar

JUL 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to July 8 1944, and that I last saw h[illegible] alive on July 7 1944.

Immediate cause of death: Myocardial infarction — Duration

Due to: Rheumatic C. V. Disease, Mitral Insufficiency

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John F. Coolahan M. D.

Address 24 N. Fulton Ave Date signed 7/8/44

C18821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 a

C18821

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 S. Decker Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Decker Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Kowalewski

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poznan, Poland (Town, county, and state)

10. Usual Occupation: Mover

11. Industry or business

FATHER
12. Name: Andrew Kowalewski
13. Birthplace: Poznan Poland

MOTHER
14. Maiden Name: Anna Pawlak
15. Birthplace: Poznan Poland

16 (a) Informant: Mrs. Lillian Denbeck
(b) Address: 623 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: German Hill Road

18 (a) Funeral director: M. J. Sadowski & Sons
(b) Address: 1808 Eastern Ave

19 (a) JUL 9 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 10 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 7 1944

G18822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G18822

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 647 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 MO

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 647 N Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Dew Newman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Lee Newman
(b) Address 647 N Central Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location New York Cemetery

18 (a) Funeral director Jack Lewis Inc
(b) Address 439 E Balto St.

19 (a) 7/9/44 (Date Rec'd by Reg.) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2, 1944 to July 8, 1944; and that I last saw him alive on July 5, 1944

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan H. Spivit. M.D.

Address 1814 Eutaw Pl. Date signed 7/9/44

Robert Lee Gresham M.D. To be approved by Medical Examiner (illegible).

G18823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G18823
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Dahlgreen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Fineman (Marie Sara Fineman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Solomon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Mendel
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel
15. Birthplace Russia

16 (a) Informant Arthur Fineman
(b) Address 3304 Bateman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

JUL 9 - 1944 (Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 3.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944, to July 8 1944, and that I last saw h[illegible] alive on July 8 1944.

Immediate cause of death Cardio respiratory failure — Duration

Due to Myocardial perforation - coronary thrombosis

Due to Coronary sclerosis

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Levin
Address Sinai Hosp Date signed 7/8/44 M. D.

G18824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

G18824
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5503 Hamlet Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1920

8. AGE: Years	Months	Days	If less than one day
23	9	0	hr. min.

9. Birthplace Pittston Pa. (Town, county, and state)
10. Usual Occupation Glenn Martin Aircraft
11. Industry or business

FATHER
12. Name Wesley P. Williams
13. Birthplace Pa

MOTHER
14. Maiden Name Catherine Bradley
15. Birthplace Pa

16 (a) Informant Lillian Williams
(b) Address Havre de Grace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16/1944 (month) (day) (year)
(c) Cemetery or crematory West Pittston, Pa.
Location

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 190 Eutaw Place
[illegible] 9-10 [illegible] Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944 at 1 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Tamponade

Due to Rupture of aorta
Aneurysm of aorta

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed July 9 1944.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct. age is especially important. Physicians: please write the

G18825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1120

G18825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4026 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida M. Wheeler

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: 10 [illegible]

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): about 1886

8. AGE: Years: 58 Months: Days: If less than one day: hr. min.

9. Birthplace: Owen Co. Ill (Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Fenton P. Lofland
13. Birthplace: Ill.

MOTHER
14. Maiden Name: Un Known
15. Birthplace: Ill.

16 (a) Informant: Dale G. Wheeler
(b) Address: 4026 Cold Spring Lane

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 9th 1944 (month) (day) (year)
(c) Cemetery ~~or Crematory~~: Oak Hill
Location: Taylorville Ill

18 (a) Funeral director: Williams Cook Inc
(b) Address: 1127 St. Paul St

19 Date received: JUL 9 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1944 to 7/8 1944, and that I last saw her alive on 7/8 1944.

Immediate cause of death: Acute Leukemia
Due to: Nephritis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration: 2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. H. Traynor M. D.
Address: Md. General Hosp. Signed 7/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G18826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18826 Registered No. 92a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Kentucky Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Kentucky Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JEANNETTE MALLALIEU

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 18, 1869

8. AGE: Years 74 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Mallalieu
13. Birthplace Reisterstown, Maryland

MOTHER
14. Maiden Name Sarah E. Sneede
15. Birthplace Baltimore, Maryland

16 (a) Informant C. Edward Mallalieu
(b) Address 611 Wyanoke Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to 7-7 1944, and that I last saw her alive on July 7 1944.

Immediate cause of death	Duration
Rheumatic heart disease -	
Aortic insufficiency & auricular	1940
Due to Embolism	
Due to	
Other Conditions Hypertension	1940

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances W. Cluck M.D.
Address 715 Park Ave Date signed 7/8/1944

G18827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G18827 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Mondawmin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Belle Thompson

3 (b) If veteran, name war W — 3 (c) Social Security Account No. None

4. Sex Female — 5. Color or race White — 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1876

8. AGE: Years about 68 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name James Thompson
13. Birthplace Unknown

MOTHER
14. Maiden Name Isabel Brooks
15. Birthplace Md.

16 (a) Informant John Bean
(b) Address 3832 Sequoia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) Date received by Local Registrar JUL 9 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944 to July 8 1944 and that I last saw h.e.r. alive on July 7 1944

Immediate cause of death — Duration
1) Bronchopneumonia — 2 wks.
Due to 2) Cerebral Hemorrhage — 5/13/44
Due to —
Other Conditions Hypertensive Heart Disease — 2
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers
Address 4108 Liberty Hts. Date signed 7/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

JO G18828
88854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G18828
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Degele

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1883

8. AGE: Years	Months	Days	If less than one day
61	-2-	17	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: —

FATHER
12. Name: John Degele
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Lena ?
15. Birthplace: Balto. Md.

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St Paul st

19 (a) Filed JUL 9 1944 (b) Registrar's signature: Clayton Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1944 to 7/7 1944, and that I last saw h alive on 7/7 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 36 hr.
Due to: HCVD & mild decompensation
Due to:
Other Conditions: Left hemiplegia, coma
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. L. Sampson
Address: 13 C H Date signed 7/7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C18829 / 1480 Registered No. C18829

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3705 S Third St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Q A Co

(c) City or town Balto - Brooklyn
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3705 S Third St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Feathers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	W	Widowed

6 (b) Name of husband or wife Arthur J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1875

8. AGE: Years	Months	Days	If less than one day
68	7	14	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Work at home

11. Industry or business

FATHER 12. Name Philip Appel

13. Birthplace Germany

MOTHER 14. Maiden Name Gertrude Auet

15. Birthplace

16 (a) Informant Mr. Edward Feathers

(b) Address 3708 6th st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Baltimore Md

18 (a) Funeral director William M Marech

(b) Address 715 Light St

19 (a) Filed 9-1944 (b) Signature by registrar Hamilton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to July 7 1944 and that I last saw h.e. alive on July 6 1944

Immediate cause of death Exhaustion — Duration 3 days

Due to Carcinoma of Uterus — 1 Year

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R L Campbell M. D.

Address 1644 Hanover Street Date signed 7/7/44

G18830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G18830

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cooperation is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Oliver St

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore Md (If outside city or town limits, give township)

(d) Street No. St Joseph's Hospital (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Mann Mann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/8/44

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John M. Mann

13. Birthplace ~~Balto Md~~ Mt Alto Pa

MOTHER

14. Maiden Name Bessie Stemple

15. Birthplace Maryland, Reedysville

16 (a) Informant Mrs John Mann

(b) Address 304 Dale St, Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)

(c) Cemetery or crematory Mont Alto

Location Mont Alto Pa.

18 (a) Funeral director Walter J Grove

(b) Address 27 E. Church St Waynesboro Pa

19 (a) JUL 9 - 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1944, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8/44 19 to 7/8 1944, and that I last saw her alive on 7/8 1944.

Immediate cause of death	Duration
Asphyxia Neonatorum	2 hr.
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Nathan E Chard

23. Signature

Address St Joseph's Hospital Date signed 7/8/44 M D

G18831 Female Dec'ed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G18831 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Jos. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto County (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Dale Ave (If rural give location)
(e) Citizen of foreign country? and (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Bessie C. Mann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John M. Mann
(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1907

8. AGE: Years	Months	Days	If less than one day
37	5	-	hr. min.

9. Birthplace Reedysville Md.
(Town, county, and state)
10. Usual Occupation House Duties
11. Industry or business

MOTHER / FATHER
12. Name Samuel D. Strayer
13. Birthplace Md.
14. Maiden Name Elsie Mayhew
15. Birthplace Md.

16 (a) Informant Mrs. John Mann
(b) Address 304 Dale Ave, Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Mont Alto
Location Mont Alto Pa.

18 (a) Funeral director Walter Y. Grove
(b) Address 27 E Church St, Waynesboro Pa
(c) JUL 9 - 1944 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-44 19 , at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6-1944 to 7-9-1944 and that I last saw her alive on 7-9-1944

Immediate cause of death Carcinoma of intestine — Duration

Due to

Due to

Other Conditions Pregnant

(Include pregnancy within 3 months of death)

Date of operation Cesarian Sec. 7-8-44

Major findings of operation: 7 mo. fetus

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Vannis M. D.
Address St. Jos. Hosp Date signed 7-9-44

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

G18832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G18832
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004-S. Clinton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004-S. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Schane

3 (b) If veteran, name war none.

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Schane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2. 1867

8. AGE: Years 77. Months 6. Days 24. If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name George W. Schape
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Schmittel
15. Birthplace Germany

16 (a) Informant Robert Schank
(b) Address 1004 S. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8 1944 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location Scappe Road

18 (a) Funeral director Waddell & Pepper
(b) Address 312 S. Howard St

19 (a) July 8 1944 Washington Wilmington N.C.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1944 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to July 6 1944 and that I last saw h alive on July 5 1944

Immediate cause of death Arteriosclerosis — Duration 8-1-43.
C.V. Disease — 8-1-43
Diabetes Mellitus — 10-3-43
Due to Cbs Cholecystitis — June 5/44
Myocardial Failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl [illegible] M. D.
Address 542 E. 21st Ave. Date signed 7-8-44

G18833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G18833 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution: Cavalcan A Home. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mth
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. North ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Anne M. Kolbe.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 11 1871

8. AGE: Years	Months	Days	If less than one day
73	1		hr. min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Amos Kolbe
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Bentz
15. Birthplace Carroll Co. Maryland

16 (a) Informant Mrs. John Wigner
(b) Address Garrison, Maryland

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Maryland

19 JUL 10 1944 (Date received by local registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1944, at 2.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to July 8 1944, and that I last saw her alive on July 7 1944.

Immediate cause of death	Duration
Edema of Lungs	3 days
Due to Chronic Myocarditis	5 yrs
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature C. Gall Wall M.D.
Address 1631 E. Northave Date signed July 7 44

G18834 ✓ X 186a G18834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. Prov. Depot Camp Holliabird Corp

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 MONS.

2. USUAL RESIDENCE OF DECEASED: # 32326 301
(a) State N.Y. (b) County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Charles Joseph O'Rourke

3. (b) If veteran, name war: NO

3. (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: UNKNOWN

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years 31 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace NEW YORK CITY (Town, county, and state)

10. Usual Occupation U. S. Army

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16. (a) Informant ARMY RECORDS
(b) Address CAMP HOLIABIRD

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 11/44 (month) (day) (year)
(c) Cemetery or crematory NEW YORK CITY
Location NEW YORK

18. (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE St.

JUL 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1944 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/7
(a) Date of injury 7-8-44 at 1.30 A M.
(b) Where did injury occur? Room 4819 Easton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from the room roof

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 7-8-44

G18835 G18835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver St
(c) Hospital or institution: St Josephs Hospital 26th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Rayleigh Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kravitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Frank S. Kravitz
13. Birthplace Plymouth Pa
14. Maiden Name Josephs Dzerzinski
15. Birthplace Baltimore Md.

16 (a) Informant Date Lorenzo
(b) Address St Josephs Hospital

17 (a) Burial, cremation, or removal (b) Date thereof July-10-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk

18 (a) Funeral director John J. Rudzinski
(b) Address 2829 Hudson St

JUL 10 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1944, to 7/9 1944, and that I last saw him alive on 7/9 1944

Immediate cause of death: Hydrocephalus Minutes — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan E. Chudi M. D.
Address St Josephs Hospital Date signed 7/9/44

G18836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G18836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha E. Lucas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31-1857

8. AGE: Years	Months	Days	If less than one day
86	11/10	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. F. Lucas
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace

16 (a) Informant Jesse G. Kaufman
(b) Address 1705 Gwyn Falls Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address McCulloh & Orchard Sts

JUL 10 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 26 1944 to July 9 1944, and that I last saw h alive on July 8 1944.

Immediate cause of death	Duration
Myocarditis	?
Due to Arterio-Sclerosis	?
Due to Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Emmett F. Conaghan M. D.
Address The Esplanade Date signed July 10 1944

G18837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d Registered No. G18837

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Whalcoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Whalcoat St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Horsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Howard Horsey
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Charlotte Johnson
15. Birthplace Carroll Co. Md.

16 (a) Informant Edmonia Horsey
(b) Address 1205 Whatcoat St
17 (a) Burial (b) Date thereof July 10 - 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director Va Brooks
(b) Address 1462 N. Carey St
(c) JUL 10 1944 (Date rec'd by registrar) Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 19 44, at 10 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to July 7 1944; and that I last saw him alive on June 16 1944.

	Duration
Immediate cause of death Cardio Vascular Disease	Unknown
Due to Hypertension Arterio Sclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Williams Frey M.D.
Address 1924 Fa Ave Date signed 7/8/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18838
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Betty Parker
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-31-94
8. AGE: Years 49 | Months 6 | Days 18 | If less than one day hr. min.
9. Birthplace W. Va. - (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John Rex -
13. Birthplace W. Va. -

MOTHER
14. Maiden Name Cardie Williams
15. Birthplace W. Va. -

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt Hally Cemetery
Location Manchester
18 (a) Funeral director A. J. Lillenstine
(b) Address Fairmont W Va
19 (a) (Date received by Registrar) (b) Registrar

JUL 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1944 5 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1944 to July 9 1944 and that I last saw her alive on 7-9 1944.

Immediate cause of death	Chronic Myeloid Leukemia	Duration
Due to	—	
Due to	Pericardial effusion due to Leukemic infiltration	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John R Brumagham M. D.
Address JHH Date signed 7/9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18839

BALTIMORE CITY HEALTH DEPARTMENT ✓ G18839
CERTIFICATE OF DEATH 93c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale Bolton Cleveland Sts.
(c) Hospital or institution West Baltimore General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 Dennison At.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth F. Ebert

3 (b) If veteran, name war ---

3 (c) Social Security Account No. Unknown

4. Sex Male

5. Color or race Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alshia Ebert

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1905

8. AGE: Years 38 | Months 9 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Beaver Falls Penna.
(Town, county, and state)

10. Usual Occupation Gasoline filling

11. Industry or business Station Operator

FATHER
12. Name Frank Ebert
13. Birthplace Ohio

MOTHER
14. Maiden Name Blanche Radaeker
15. Birthplace Penna.

16 (a) Informant Mrs. Alshia Ebert
(b) Address 740 Dennison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July. 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) ... (Date received by registrar) (b) ... (Registrar)

JUL 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1944, to 7-9 1944, and that I last saw him alive on 7/9 1944.

Immediate cause of death C.P.C. — Duration ...

Due to Rheumatic C.V.D. — Duration ...

Due to ... — Duration ...

Other Conditions ... — Duration ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Lucius L. Baldwin M.D.
Address W.B.G.H. Date signed 7/9/44

G18840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 121

Registered No. G18840

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 BARTLETT AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Wardle

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-3632

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma L. Brese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1896

8. AGE: Years 48 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace New Jersey (City, county, and state)

10. Usual Occupation Credit Manager

11. Industry or business Eastberg Co.

FATHER 12. Name Andrew R. Wardle

13. Birthplace Penna.

MOTHER 14. Maiden Name Annie C. Fairbanks

15. Birthplace Balto. Maryland

16 (a) Informant Mrs. Emma Wardle

(b) Address 628 Bartlett ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Nitke

(b) Address 4101 Edmondson ave.

19 (a) JUL 10 1944 (Date received by registrar) (b) Registrar Wm. A. Taylor M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944, to July 7 1944, and that I last saw him alive on July 7 1944

Immediate cause of death Generalized peritonitis due to ruptured appendix — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul G. Lukeato M.D.

Address 1213 Light St. Date signed 7/7/44

G18841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G18841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 W. Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits write RURAL and give town)
(d) Street No. 704 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Buntenig

3 (b) If veteran, name war

3 (c) Social Security Account No. 567-03-0843

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Unskilled

11. Industry or business Eastern Aircraft

FATHER 12. Name Thomas Buntenig

13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Watson

15. Birthplace Ireland

16 (a) Informant Mr. George Buntenig

(b) Address 704 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Balto. Md.

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 Edmondson Ave.

JUL 10 1944 (Date rec'd by registrar)

(a) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to July 9 1944 and that I last saw h[illegible] alive on July 9 1944.

Immediate cause of death	Duration
Acute cardiac Dilatation	2 hrs.
Due to Myocarditis	2
Due to	
Other Conditions Liver Cirhosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Klemman M. D.

Address 753 W. Fayette St Date signed 7/10/44

T.G.P.-88684

G18842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E G18842

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 2 E 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 533 W. Berry Street (If rural give location)

(e) Citizen of foreign country? Negro No (Yes or No)

If yes, name country

3 (a) FULL NAME Prince Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Kennedy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1898

8. AGE: Years 46 | Months | Days 19 | If less than one day: hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Street Cleaner

11. Industry or business

FATHER

12. Name P.F.Kennedy

13. Birthplace South Carolina

MOTHER

14. Maiden Name Theresa ?

15. Birthplace South Carolina

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)

(c) Cemetery or crematory Lynchburg S C

Location

18 (a) Funeral director Isaiah T. Burwell

(b) Address 1018 W Montgomery St

19 (a) JUL 10 1944 (b) Baltimore Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944 at 4:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1944, to July 9 1944, and that I last saw him alive on July 8 1944

Immediate cause of death Cardiac failure — Duration Months.

Due to Syphilitic cardiovascular disease and aortic insufficiency — Duration ?

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H.B. Berry, Jr. M.D. M. D.

Address Balto City Hosp Date signed 7/9/44

G18843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a Registered No. G18843

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Grave Sts
(c) Hospital or institution: Emergency Hospital 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Read St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME William Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: B
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/1/44
8. AGE: Years — Months 3 mo. Days 8 If less than one day — hr. — min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business —

FATHER
12. Name Mack Millan
13. Birthplace N.C.

MOTHER
14. Maiden Name Julia Brown
15. Birthplace S.C.

16 (a) Informant Julia Brown
(b) Address 1102 Read St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location E. N. Co. Md
18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 101 W Montgomery St
19 (a) (Date rec'd by registrar) (b) (Registrar)

VS JUL 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944 at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1944 to 7/9 1944 and that I last saw him alive on 7/9 1944.

Immediate cause of death: Respiratory failure — Duration 15 min
Due to: Anemia — Duration 4 days
Due to: Dehydration from Diarrhea
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Alfred L. Nelson M. D.
Address Emergency Hospital Date signed 7/9/44

G18844

BALTIMORE CITY HEALTH DEPARTMENT ✓ G18844

CERTIFICATE OF DEATH 55L

Registered No.

G18844

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 7 N 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Jefferson Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Brodie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Yohai

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Leth
13. Birthplace Lith

MOTHER 14. Maiden Name Faggi
15. Birthplace Lith

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 7-10-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Louthers Am
Location Louthers Am

18 (a) Funeral director Jack Levin Inc
(b) Address 1437 E. Balto St

19 (a) (b) Hunter Grayton Hilleard, M.D. Registrar
(Date rec'd by registrar)

JUL 10 1944

VS-10

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944, at 7.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1944, to 7/10 1944, and that I last saw h[illegible] alive on 7/8 1944.

Immediate cause of death Cardiac Respiratory failure — Duration

Due to Degenerative Arteriosclerosis Brain

Due to Carcinoma Pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lonard E Menken M. D.
Address Sinai Hosp. Date signed 7/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

618845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 61

618845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2429 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Slesinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
78				

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 7-11-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Helem
Location Belair Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (b)
(Date rec'd by registrar)

JUL 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-10-44 19 . at 2 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1935 to July 10 1944, and that I last saw him alive on July 10 1944

Immediate cause of death Coronary Occlusion — Duration 5 hrs.

Due to Hypertension, Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus Chronic Cholecystitis — 40 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Seidel M. D.
Address 14 S. Broadway Date signed 7/10/44

G18846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

G18846 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 442 N. Patterson Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 442 N. Patterson Pk Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel E. Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Myer #

13. Birthplace Russia

MOTHER 14. Maiden Name Rosa

15. Birthplace Russia

16 (a) Informant Wife

(b) Address

17 (a) Burial (b) Date thereof 7-11-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wash. Hebr.

Location Wash. Hebr.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1432 E. Balto St

19 (a) (b)

(Date rec'd by registrar) Registrar

VR/150 JUL 10 1944 Interim Director Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8-44 19 , at ✓ P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1935 to July 8 1944 and that I last saw h/ alive on July 6 1944

Immediate cause of death Decreasing emaciation

Cardio-renal vascular disease

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 yrs
8 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature David Schneeweiss M. D.

Address 1101 N. Milton Ave Date signed 7-10-44

G18847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G18847 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles Menkel (Charles O. Menkel)

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 213-01-7286

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Lavinia Menkel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/79188/

8. AGE: Years 65 | Months 3 | Days 27 | If less than one day — hr. — min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Clothing Cutter

11. Industry or business J. Schoenman

FATHER
12. Name George Menkel
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Richards
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Lavinia A. Menkel
(b) Address 1909 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS.
(b) Address Balto., Washington Blvd. and Monroe St.

19 (a) JUL 10 1944 (b)
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944, to July 7 1944, and that I last saw h. l. m. alive on July 7 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 4 days
Due to —
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature Chas. Norton, Jr
Address Bon Secours Hosp. Date signed 7/8/44

OVER

G18848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316 Registered No. G18848

MARGIN RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7419 Old Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Hochrein

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-01-6913

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1918

8. AGE: Years 26 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Commercial Credit

FATHER
12. Name George F. Hochrein
13. Birthplace Germany

MOTHER
14. Maiden Name Alice Weyerts
15. Birthplace Md (Balto.)

16 (a) Informant Mrs. Clare Jenkins
(b) Address 7419 Old Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Washington Boulevard, Md.

19 (a) JUL 10 1944 (b) Registrar
(Registered by city)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/44 19 at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5/44 19 to 7/8/44 19 and that I last saw her alive on 7/8/44 19

Immediate cause of death	Duration
Uremia	
Due to Chronic Glomerulonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature William J. Bryson M. D.

Address St. Agnes Hosp. Date signed

G18849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G18849
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORDELIA BREITENGROSS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Alfred T. Breitengross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 2, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	7	hr. min.

9. Birthplace Orwigsburg, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Kocher
13. Birthplace Pa.

MOTHER
14. Maiden Name -- Boyer
15. Birthplace Pa.

16 (a) Informant Mr. Alfred T. Breitengross
(b) Address 819 N. Payson St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Evan
Location Orwigsburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 10 1944 Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1944, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to July 9 1944, and that I last saw h[illegible] alive on July 8 1944.

Immediate cause of death — Duration

Coronary Thrombosis — 9 days

Due to arterio sclerosis — months

Hypertension & Diabetes.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Brennan Lord M. D.
Address 2200 Garrison Blvd Date signed 7/10/44

G18850

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

18 Ken G18850 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Washington Blvd (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Anna M. Naylor

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Thomas Naylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Febry 22, 1875

8. AGE: Years 69 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Ephriam Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Watson
15. Birthplace Ireland

16 (a) Informant Mr Lawrence C. Della
(b) Address 925 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Edmondson Ave. Longwood St

18 (a) Funeral director John J. Cashman & Son
(b) Address 2163 Wallbus Street

19 (a) JUL 10 1944 (Date city received) Hugh [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th, 1944 at 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to July 8 1944.
and that I last saw her alive on July 3 1944.

Immediate cause of death: Arteriosclerotic cardiac degeneration — Duration 10 years
Senility
Due to: MSM or DS.
Due to:
Other Conditions: Compound fracture left femur
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 4/2
(b) Date of occurrence June 24, 1944
(c) Where did injury occur? University Hosp, Balto, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? University Hospt. While at work? No (Specify type of place)
(e) Means of injury fell at home again at the hospital

23. Signature Paul A. Turnbull, M. D.
Address [illegible] Date signed 7/9/44

VS 3

Affidavit by Attorney of Executrix

G18851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111a

G18851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N. Luzerne ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Luzerne ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfonsina Andresini

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Pasquale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 - 1893

8. AGE: Years	Months	Days	If less than one day
51	2	12	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Michael Mancini
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Lorando
15. Birthplace Italy

16 (a) Informant Husband
(b) Address 407 N. Luzerne ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location

18 (a) Funeral director Frank V. Pipitone
(b) Address 28[illegible] E. Baltimore st

JUL 10 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th 1944, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18th 1944 to July 8th 1944 and that I last saw h[illegible] alive on July 8th 1944

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Bilateral Pulmonary Infarct	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Janken M. D.
Address 100 N. Milton Date signed 7/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~4618858~~ G18852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

512

G18852 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 W Lafayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-86

8. AGE: Years 57 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation JANITOR

11. Industry or business Catholic Home

FATHER 12. Name William Robinson

13. Birthplace Ala

MOTHER 14. Maiden Name Caroline (?)

15. Birthplace Ala.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director George H. Kelson

(b) Address 303 Presstman St Huntington Station, Md.

19 (a) JUL 10 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to July 7 1944, and that I last saw HIM alive on July 7 1944.

Immediate cause of death ~~Hypostatic pneu~~ Septicemia — Duration 6-8 wks

Due to Calcinoma of stomach with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham JHH

Address Date signed 7/8

G18853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

Registered No. G18853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Lawrence St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1904

8. AGE: Years	Months	Days	If less than one day
39	11		hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Washington
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Jones
15. Birthplace Va

16 (a) Informant Hannah Burrell
(b) Address 1333 N Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 12 44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Pennsylvania Ave

19 (a) JUL 10 1944 (Date received) (b) Hunting Towers Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to July 7 1944, and that I last saw her alive on July 6 44

Immediate cause of death: Cardio respiratory failure — Duration

Due to: Cachexia due to intestinal fistula

Due to: Appendiceal abscess

Other Conditions: Lymphogranuloma venereum — 7 yrs

(Include pregnancy within 3 months of death)

Date of operation 6/3/44

Major findings of operation: Appendiceal abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J R Gaither

Address Mercy Hosp Date signed 7/5/44

G18854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V G18854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 S. Calhoun St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

1913

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S. Calhoun St. 233. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a). FULL NAME Virginia F. Blum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed.
6 (b) Name of husband or wife Michael G. Blum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1864

8. AGE: Years 80 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace St Mary's Co. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Frank Abell.
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name ~~Catherine~~ Unknown
15. Birthplace St Mary's Co Md

16 (a) Informant Mrs. Helen Blum
(b) Address 233 S Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director Wm J. Kenny
Address Hollins & Gilmor

19 JUL 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th 1944, at 9 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to July 7 1944 and that I last saw h alive on 19

Immediate cause of death ~~Coronary~~ arterio sclerotic cardio vascular disease — Duration 6 months

Due to —

Due to —

Other Conditions Gangrene of Rt Leg — 4 months

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Benjamin Miller MD M. D.
Address 2030 Wilkens Ave Date signed 7/10/44

G18855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195C

G18855 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 Kinston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Kinston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Storre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Geneva M. Storre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/87

8. AGE: Years	Months	Days	If less than one day
73	6	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Stereotyper
11. Industry or business Newspaper.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Geneva M. Storre
(b) Address 819 Kinston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry T. Annacott
(b) Address 420 Reisterstown Rd

19 JUL 10 1944 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1944 at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2, 1944 to July 8, 1944 and that I last saw him alive on July 8, 1944.

Immediate cause of death: Cardiac Insufficiency — Duration 2 mos.
Due to: Arteriosclerosis
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None

23. Signature Sidney L. Levy M. D.
Address 2322 Eutaw Place Date signed 7-8-44

G18856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1161 G18856 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cooper & Lakeland Ave
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Fulton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sharon Lee Maurer
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Father Raymond James
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 3, 1944
8. AGE: Years — Months — Days 5— If less than one day hr. min.
9. Birthplace W. B. D. H. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Raymond James Maurer
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Martha Anna Chester
15. Birthplace Balt. Md.

16 (a) Informant Raymond J. Maurer
16 (b) Address 23 N. Fulton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
17 (c) Cemetery or crematory Western Location Baltimore, Md.
18 (a) Funeral director F. A. Hofheimer & Son
18 (b) Address 1300 Eutaw Place
19 (a) (Name of informant) (b) Registered JUL 10 1944 Vs 150 Huntington Milwaukee Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 8 45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1944, to July 8 1944, and that I last saw her alive on July 8 1944.

Immediate cause of death	Duration
(a) Lung.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Paul N. Friedman
Address Med Bal Jail Hosp Date signed 7/10/44

G18857 GURSELSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 185

G18857 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 S. Montford ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Gurbelski

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Bottling

11. Industry or business Soda Water

FATHER
12. Name Paul Gurbelski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Sniegowska
15. Birthplace Poland

16 (a) Informant Victoria Gurbelski
(b) Address 619 S. Montford Ave

17 (a) Burial (b) Date thereof 7-11-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location German Hill Rd

18 (a) Funeral director Wm. L. Fiallkowski
(b) Address 1947 Eastern Ave

19 JUL 10 1944 (b) Huntington Ave Baltimore, Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8- 1944, at 8:15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to severed
Carotid Artery & Internal jugular vein

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-8-44 at 8 A. M. 1/3
(b) Where did injury occur? Room 9 619 S. Montford Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Flying glass broken bottle

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 7-8-44

G18858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G18858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Rose Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Rose Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Moravek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Agnes (nee Masek)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/87

8. AGE: Years 57 yrs. | Months 4 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork & Seal

FATHER
12. Name Frank Moravek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Svanhauser
15. Birthplace Czechoslovakia

16 (a) Informant wife
(b) Address 822 N. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) JUL 10 1944 (Date received by Registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944 to July 7 1944 and that I last saw h alive on 19

Immediate cause of death: Hypostatic Pneumonia — Duration 7/3/44

Due to:

Due to: Carcinoma of Rectum — 1/1/44

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dykaver R.

Address 801 N Kenwood Ave Date signed 7/8/44

G18859

456747.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G18859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHN HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Fairhaven Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Pecukonis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Vincent
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 1-31-90

8. AGE: Years	Months	Days	If less than one day
54	5	6	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name John Seggler.
13. Birthplace Poland.

MOTHER
14. Maiden Name Mary Kualowska.
15. Birthplace Poland.

16 (a) Informant Relnd.
(b) Address John Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location Anne Arundel County

18 (a) Funeral director John M. Weber
(b) Address 404 S. Chester Street

JUL 10 1944 (b) Date received Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944, to July 7 1944, and that I last saw her alive on July 7 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral hemorrhage	
Due to Hypertension Cardiovascular Disease	
Other Conditions Arteriosclerosis, generalized	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Spurrier III
Address John Hopkins Hospital Date signed 7-7-44 M. D.

G18860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

146c

G18860 Registered No.

MARK "RESERVED FOR READING" OR "RESERVED FOR STATISTICS" IN UNUSED SPACES.
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: ST. AGNES HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Balto. Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 Vogt. - 27 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Spence 304347

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Joseph V. Spence
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1908

8. AGE: Years 35 | Months 10 | Days 11 | If less than one day: hr. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER — 12. Name Frank D. McFadden
13. Birthplace Pa.

MOTHER — 14. Maiden Name Annie Michel
15. Birthplace Balto. Md.

16 (a) Informant Joseph V. Spence
(b) Address 1244 Vogt Ave. Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory Westerns
Location Baltimore

18 (a) Funeral director C. R. Kaufman
(b) Address 1026 Leeds Ave.

19 (a) JUL 10 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7- 1944, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1944 to 7-7 1944, and that I last saw her alive on 7-7 1944.

Immediate cause of death: Post operative Shock
9 hours age
Due to: Caesarian operation
Due to: Placenta Previa with hemorrhage

Duration
over

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Bowyer M. D.
Address Med Arts Bldg signed 7/7/44

G18861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G18861 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special care is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1244 Orleans St
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marcellina Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	widowed

6 (b) Name of husband or wife William Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24, 1880

8. AGE: Years	Months	Days	If less than one day
63	10	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Benjamin Diggs
13. Birthplace Md

MOTHER
14. Maiden Name Harriett Ann Henderson
15. Birthplace Md

16 (a) Informant Viola Braxton daughter
(b) Address 1249 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/44 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location Arbutus Memorial Pk

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brookley Ave

19 (a) (Date received by local registrar) (b)

JUL 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to July 8 1944, and that I last saw her alive on July 8 1944.

Immediate cause of death Chronic Nephritis (uremia) — Duration 5 Years

Due to

Due to

Other Conditions Diabetes Mellitus Hypertension and Arteriosclerosis — Duration 1 Yr.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph E. Young M. D.
Address 1724 E. Monument Date signed 7/8/44

G18862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G18862
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Maine Ave.
(c) Hospital or institution:

15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUMNER T. BISBEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4, 1866

8. AGE: Years	Months	Days	If less than one day
77	4 9	5	hr. min.

9. Birthplace Keokuk, Iowa
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John M. Bisbee
13. Birthplace Mass.

MOTHER
14. Maiden Name Abbie Tyler
15. Birthplace New York

16 (a) Informant Mr. Warren T. Bisbee
(b) Address Chicago, Ill.

17 (a) Burial (b) Date thereof 7/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams M.D.
(Date received by registrar) Registrar

JUL 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1944, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to July 9 1944, and that I last saw h alive on July 7 1944.

Immediate cause of death
Hypertensive Arteriosclerotic → Heart Disease with
Due to Congestive Failure
Due to
Other Conditions Senility

Duration
Yrs.
1 wk.
Years.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert W. Garis M. D.
Address 1014 St. Paul St. Date signed 7/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G18863 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Frederick Ave
(c) Hospital or institution: Mt.St.Joseph College 25 yrs
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St.Mary's Ind School. (If rural, give location) No.
(e) Citizen of foreign country? (Yes or No)
If yes, name country * * * * * * * *

3 (a) FULL NAME Brother Sebastian C.F.X.(William Donnelly)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single * * *

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4-1877

8. AGE: Years 67 | Months 5 | Days 4 5 | If less than one day hr. min.

9. Birthplace Jarrow EnTyne, England. (Town, county, and state)
10. Usual Occupation Regilous-Xaverian Brother.
11. Industry or business

FATHER
12. Name ** Donnelly
13. Birthplace England.

MOTHER
14. Maiden Name Don't know
15. Birthplace England

16 (a) Informant Records; StMary's Ind. School
(b) Address Wilkens & Caton Avenues.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road
18 (a) Funeral director Chas. F. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Avenue
19 (a) (Date received by registrar) JUL 10 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9- 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to July 9 1944 and that I last saw him alive on July 6 1944

Immediate cause of death: Hypostatic pneumonia; C-V-D Senility. Arteriosclerosis

	Duration
Due to	
Due to	
Other Conditions Pulmonary Oedema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Kitchen, M.D.
Address 251 Wilkens Ave. Date signed July 11 44

G18864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18864 Registered No.

MARK RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 S. Streeper
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County 9th
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 644 S. Streeper (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eliese (Elese) M. Eisel

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Eisel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1854

8. AGE: Years 90 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name John Hupfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Anne E. Eng
15. Birthplace Germany

16 (a) Informant Mrs William Hinderer
(b) Address 4300 Fonstown Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location a. a. Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Edgewood

19 JUL 10 1944 (Date received) H. Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944 at 945 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4th 1943 to July 9th 1944, and that I last saw her alive on July 8th 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs
Due to Hypertension and arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Faulkner M. D.
Address 1002 N. Mulberry Date signed 7/8/44

MARK IN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

Reg. G18865

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1935 Light St
(c) Hospital or institution:

24-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Wingate

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace A. Wingate
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 12, 1881

8. AGE: Years 63 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business Lath Insulater

FATHER
12. Name Zacharia Wingate
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Rebecca Scholsles
15. Birthplace Balto. Md

16 (a) Informant Grace A. Wingate
(b) Address 1935 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1944 (Month, day) (Year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director G. Bouyed Evans
(b) Address 1400 Lombard St

19 (a) JUL 10 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944, at 845 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1944 to July 9 1944 and that I last saw [illegible] alive on July 9 1944.

Immediate cause of death: Ephanotrax — Duration: 2 Ds
Due to: Cerebral Hemorrhage — 2 Wks
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. L. Campbell M.D.
Address 164 W Hamburg Date signed 7/10/44

VS 150

G18866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18866

Registered No. 132

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1122 Wilmer Court

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1122 Wilmer Court (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marie Brown Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1914

8. AGE: Years 30 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Robert Brown

13. Birthplace Va.

14. Maiden Name Rosa Brown

15. Birthplace Va.

16 (a) Informant Rev. Brown

(b) Address 1122 Wilmer Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

JUL 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1944 to 7/7 1944 and that I last saw h[illegible] alive on July 7 1944

Immediate cause of death: Pulmonary T.B. — Duration 6 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 7/9/44

G18867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G18867
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — 1 4
(If outside city or town limits write RURAL and give town)
(d) Street No. 311 W. Hoffman St.
(Number and give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
80?			hr. min.

9. Birthplace Va, (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Palm Restaurant

FATHER
12. Name Oliver Jackson
13. Birthplace Va,

MOTHER
14. Maiden Name Tiny Forrest
15. Birthplace Va.

16 (a) Informant Sam
(b) Address Preston & Lindsay Ave.

17 (a) Burial (b) Date thereof 7/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b)
(Date received by registrar) Registrar

JUL 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/44, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1944 to 7/9 1944, and that I last saw him alive on 7/6 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Acute Congestive Heart Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. M. McCloskey
Address Mercy Hospital Date signed 7/7

G18868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G18868 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Tucker

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name George Burton

13. Birthplace N. C.

14. Maiden Name Bessie Johnson

15. Birthplace N. C.

16 (a) Informant Louise Burton

(b) Address 201 Sharp St.

17 (a) Burial (b) Date thereof 7/11/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

19 (a) JUL 10 1944 (b)
(Date rec'd by Reg.) Registrar

H. Burton Hollowell, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6- 1944, at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Acute Coryza Cardiac Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

(e) Signature Howard J. Nelson M.D.
Medical Examiner.

Date signed 7-6-44

G18869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G18869

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3950 Hickory Avenue (Or rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rayna G. Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James C. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 31 1898

8. AGE: Years: 46 | Months: 5 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Page Co. Virginia (town, county and state)
10. Usual Occupation: Dom. Teacher Dept. of Education
11. Industry or business: Baltimore City

FATHER — 12. Name: Martyn Breedon
13. Birthplace: Virginia

MOTHER — 14. Maiden Name: Elizabeth Comer
15. Birthplace: Virginia

16 (a) Informant: Mrs. C. Williams
(b) Address: 3950 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 11-1944 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Park
Location: Baltimore Co. Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3431 Pipe Road

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Hillsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/44 19 , at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31 1944, to 7/8 1944, and that I last saw her alive on 7/8 1944.

Immediate cause of death	Duration
Cachexia	
Due to Fecal fistula	
Due to Cholecystectomy	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/3/44
Major findings of operation: Chr. Cholecystitis & Stone
of autopsy: in common duct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. H. Traynor M. D.
Address: Md. Gen. Hosp. Date signed: 7/8/44

G18870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927 D

Registered No. G18870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly answered. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 E. 42nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 E. 42nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella G. Fox

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27- 1857

8. AGE: Years 86 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name John Day Gresset
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia E. Muse
15. Birthplace Va.

16 (a) Informant Mrs. Ethel F. Burgan
(b) Address 509 E. 42nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-44 (month) (day) (year)
(c) Cemetery or crematory Forest Hill
Location Towson Md.

18 (a) Funeral director John A. Inman
(b) Address 4201 Greenmount Ave
(c) Date received JUL 10 1944 Wilmington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to July 9 1944 and that I last saw h[illegible] alive on July 8 1944.

Immediate cause of death Myocarditis Interstitial

Duration

Due to General arteriosclerosis

Hemiplegia (Left sided)

Due to Chronic Endocarditis

Other Conditions Renal Calculi

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel J. McGinnis Jr.
Address 111 Allegheny Ave. Towson Md. Date signed 7/10/44

VS 3

G18871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

516

Registered No. G18871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank V. McKinstry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed.

6 (b) Name of ~~husband or~~ wife Blanche S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1871

8. AGE: Years 72 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace N. J.
(Town, county, and state)

10. Usual Occupation Mech Engr.

11. Industry or business Bowman Refrigerator Co.

FATHER 12. Name Charles McKinstry

13. Birthplace Pa.

MOTHER 14. Maiden Name Martha Blaker

15. Birthplace Pa.

16 (a) Informant Hospital Records

(b) Address

17 (a) Cremation (b) Date thereof 7/12/44
(~~Burial~~, cremation, or ~~removal~~) (month) (day) (year)

(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 217 St Paul St.

19 (a) [illegible] Huntington Williams, M.D.
Registrar

JUL 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-44 19 , at 4.06 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-44 19 , to 7-9-44.
and that I last saw h.c.~~m~~ alive on 7-9-44

Immediate cause of death Uremia.

Due to Ca of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Hampton Reid M. D.

Address Univ. Hosp Date signed 7-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G18872 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Church Home & Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore 5
(c) City or town Baltimore #29.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Maiden Choice Rd
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Connelly, Mr Valentine J.

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. 212-03-9792

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Connelly Mrs Emma

6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.): Feb 14 1884

8. AGE: Years 60 | Months 4 | Days 25 | If less than one day hr. .....min.

9. Birthplace: Australia (Town, county, and state)

10. Usual Occupation: Accountant

11. Industry or business: Stegman & House

MOTHER / FATHER

12. Name: Connelly, Valentine

13. Birthplace: Australia

14. Maiden Name: Howard, Mary

15. Birthplace: Australia

16 (a) Informant: Emma Connelly

(b) Address: 1226 Maiden Choice Rd

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)

(c) Cemetery or crematory: Greenmount

Location: Greenmount Ave & 31st St

18 (a) Funeral director: Wilson Funeral Home

(b) Address: 1217 E Baltimore St

19 (a).....(Date received by Registrar) (b) Huntington Williams M.D. Registrar

JUL 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944, at 3:7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944 to July 9 1944, and that I last saw him alive on July 6 1944.

Immediate cause of death: Aspiration of Vomitus Post-Operative — Duration: 2 hours

Due to: Carcinoma of Gall Bladder — Duration: ?

Due to: Cirrhosis Liver Metastases

Other Conditions: Syphilis - Latent
(Include pregnancy within 3 months of death)

Date of operation 7-6-44

Major findings of operation:.....

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. M Culler M. D.

Address Church Home & Hosp Date signed 7-9-44

G18873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G18873

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert

(c) Hospital or institution: Union Memorial Hosp. 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

City or town Baltimore Co. 12

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6000 Belleau Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ida S. Todd

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/25/1868

8. AGE: Years	Months	Days	If less than one day
76	4	14	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ~~Retired~~ Practical Nurse

11. Industry or business

FATHER — 12. Name	Ephriam Dreffendafer
FATHER — 13. Birthplace	Pa.
MOTHER — 14. Maiden Name	Matilda Biery
MOTHER — 15. Birthplace	Pa.

16 (a) Informant Geo H. Todd

(b) Address 127 N. Elwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 (Month) (Day) 44 (Year)

(c) Cemetery or crematory Spring Hill Cemetery

Location Easton, Md.

18 (a) Funeral director John Quitchell Sons

Address Hectar Reace

19 (a) JUL 10 1944 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 1944, at 8:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1944, to 7/7 1944, and that I last saw h.... alive on 6/7 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Lytle M. D.

Address Union Memorial Hosp. Date signed 7/9/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

G18874

AB-88895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

G18874
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leaon Leon Kirby

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Corrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October-15-1912

8. AGE: Years	Months	Days	If less than one day
31	8	8 24	hr. min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name Eugene Clark
13. Birthplace West Virginia

MOTHER: 14. Maiden Name Clara Cooper
15. Birthplace West Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-10-44 (month) (day) (year)
(c) Cemetery or crematory
Location Fairmont W Va

18 (a) Funeral director Geo T Bowyer Jr
(b) Address 1512 Hollins St

(a) (Registrar) JUL 10 1944 (b) Huntington W Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9- 1944, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1944, to 7/9 1944, and that I last saw h[er] alive on 7/9 1944

Immediate cause of death Pheumatic heart disease, mitral stenosis & insufficiency, aortic stenosis — Duration: years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. F. Jerpinan M. D.
Address BCH Date signed 7/10

C18875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 58c

Registered No. C18875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Wildwood Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Wildwood Pkwy. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Henry Jackson Calder

3 (b) If veteran, name war None

3 (c) Social Security Account No. 705-07-1721

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth T. Calder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20-1903

8. AGE: Years 40 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Kent Co. Md (Town, county and state)

10. Usual Occupation Sheet Clerk B&O RR

11. Industry or business Railroad

FATHER
12. Name Wright Calder
13. Birthplace Md

MOTHER
14. Maiden Name Maude V. Thompson
15. Birthplace Md

16 (a) Informant Mrs. Ruth T. Calder
(b) Address 602 Wildwood Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Bel Air Md

18 (a) Funeral director Geo. T. Berger Jr.
(b) Address 157 Hollins St

19 Date received 7-10-1944 Hunter Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 to July 8 1944, and that I last saw h[illegible] alive on July 7 1944.

	Duration
Immediate cause of death: Thrombosis Collapse.	6 hrs
Myocarditis.	
Due to Rheumatic Heart	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert K. Mortensen M.D.
Address 2766 St Paul St Date signed 7-8-44

G18876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G18876 Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 White Oak Grove
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 White Oak Grove (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Elizabeth Hawkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Jesse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1891

8. AGE: Years	Months	Days	If less than one day
53 52	11	7	hr. min.

9. Birthplace Charles County Md. (Town, county, or state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Solig Coleman
13. Birthplace Charles County Md.

MOTHER
14. Maiden Name Henrietta Bowyer
15. Birthplace Charles County, Md.

16 (a) Informant Jesse Hawkins
(b) Address 1110 White Oak Grove

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Fredrick Road

18 (a) Funeral director Mrs. R. O. Elliott & Jr.
(b) Address 129 N. Carlton St. Huntington Williamsport, Md.

JUL 10 1944

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 44 at 12:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 8 1944, to July 8 19 44 and that I last saw him alive on July 8 19 44

Immediate cause of death	Duration
Cerebral Accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Julius Stohte M. D.
Address 1543 Penna Ave Date signed 7-10-44

G18877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G18877 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary Steinmetz.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: James F. Steinmetz | 6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 28. 1890

8. AGE: Years 53 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph Kalista
13. Birthplace Bohemia

MOTHER 14. Maiden Name Anna Kalub
15. Birthplace Bohemia

16 (a) Informant James F. Steinmetz
(b) Address 632 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brockson
(b) Address 900 N. Chester St

JUL 10 1944 (a) (Date received by registrar) (b) Hamilton Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944, at 12.01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1944, to 7-9 1944, and that I last saw her alive on 7-8 1944.

Immediate cause of death: Coronary Occ. — Duration 7 hrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 6-24-44

Major findings of operation: Fibroids uterus, Chronic appendicitis

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel, Jr. M. D.

Address Bon Secours Hosp. Date signed 7-9-44.

G18878 S.C.P. 88423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G18878

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thompson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1944

8. AGE: Years | Months | Days: One | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harvey Tompson
13. Birthplace Virginia

MOTHER
14. Maiden Name Edna Johnson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremation 10AM (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

JUL 11 1944 (Date rec'd by registrar) (b) Hampton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1944 19..., at 6:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8-44 19... to 6-8 19 44
and that I last saw h[illegible] alive on 6-8 19 44

Immediate cause of death	Duration
Suffocation	
Due to aspiration, food	
Due to	
Other Conditions premature 30-wks.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Bolton Jr. M.D. M. D.
Address Balto. City Hosp. Date signed 6/9/44

G18879 T.G.P.--88741 BALTIMORE CITY HEALTH DEPARTMENT 160a G18879

CERTIFICATE OF DEATH

Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Venable

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1944

8. AGE: Years | Months | Days | If less than one day: 25 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Berkley Venable
13. Birthplace Virginia

MOTHER
14. Maiden Name Aileen Mallory
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremation 10 AM (b) Date thereof July 7, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Baltimore City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 29 1944, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28 1944, to 6-29 1944, and that I last saw her alive on 6-28 1944.

	Duration
Immediate cause of death Intracranial Hemorrhage	25 hr.
Due to Birth Injury	25 hr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Perry, Jr. M.D.
M. D.
Address Balto. City Hosp. Date signed 6/29/44

G18880
70 788671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30f

Registered No. G18880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Kimberlain-(Melville)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1944

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Kimberlain
13. Birthplace Unable to obtain information

MOTHER
14. Maiden Name Melville White
15. Birthplace Ohio

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Cremation 10AM (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Baltimore City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address Huntington Williams, M.D.

19 (a) JUL 11 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1944, at 6:55AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1944, to 6-25 1944, and that I last saw him alive on 6-25 1944.

Immediate cause of death: Congenital Syphilis — Duration

Due to — Duration

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Congenital Syphilis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Kerr Jr. M.D. M. D.
Address ~~H. H. Kerr Jr. M.D.~~ Balts. City Hosp. Date signed 6/28/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

MARGIN RESERVED FOR BINDING

G18881
Reg. #88772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G18881
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da. 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Broadway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Breeding-Eva

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1944

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Garvie Wilkerson
13. Birthplace Virginia

MOTHER
14. Maiden Name Eva Breeding
15. Birthplace Virginia

16. (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremation 10 AM (b) Date thereof July 7, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Baltimore City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

JUL 11 1944 (c) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1944, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944 to 6-30 1944, and that I last saw her alive on 6-30 1944

Immediate cause of death	Duration
INTRA CRANIAL Hemorrhage	
Due to Birth Injury	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Berry J. M.D.
(M. D.)
Address Balto City Hosp Date signed 7/6/44

G18882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G18882

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 W Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Androlunas (Andres)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife James
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1883
8. AGE: Years 61 Months Days If less than one day hr. min.
9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lyth

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant James Andres
(b) Address 814 W Lombard St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd
18 (a) Funeral director Joseph Lasmokes Jr
(b) Address 620 Washington Blvd
19 (a) JUL 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to July 7 1944, and that I last saw her alive on July 7 1944.

Immediate cause of death Carcinoma Recto-sig meridal Jonction — Duration 2 yrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation July 7. 1944

Major findings of operations Carcinoma

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carey A Rostring M. D.
Address 1316 W Lombard St Date signed 7/8/44

G18883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G18883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Randolph M. Welch

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-01-6044

4. Sex: M.
5. Color or race: W.
6 (a) ~~Single, married, widowed, or~~ divorced. Separated
6 (b) Name of ~~husband or~~ wife Belle Welch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1881

8. AGE: Years 62 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Mechanic.
11. Industry or business Frieze

FATHER
12. Name Rosia W. Welch
13. Birthplace Winchester, Va.

MOTHER
14. Maiden Name Hattie Mulford
15. Birthplace Georgia

16 (a) Informant L. K. Minbigler
(b) Address 3007 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William Bok, Inc.
(b) Address 217 St. Paul St.

JUL 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10/44 19 at 7-05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19/44 19 to 7/10/44 19 and that I last saw him alive on 7/10/44 19

Immediate cause of death Carcinoma of lung. — Duration several months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Wagner M. D.
Address Md. General Hosp. Date signed 7/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓

G18884 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 328 E. 25th st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 328 E. 25th st (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Horney

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Carrie Horney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1866

8. AGE: Years 77 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace Easton Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Farmer

FATHER: 12. Name James Pascalt Horney

13. Birthplace Md

MOTHER: 14. Maiden Name Elizabeth Elliott

15. Birthplace Md.

16 (a) Informant Miss Ruth Horney

(b) Address 328 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 (a) 7 11 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1944, at 2 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1941, to July 9 1944, and that I last saw h alive on July 8 1944.

Immediate cause of death: Myocardiitis — Duration: years

Due to Arterio-Sclerosis generalized — years

Due to — years

Other Conditions Hypertension — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry L. Hermon M. D.

Address 328 E. Pratt Street Date signed 7/10/44

G18885 - 78502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

G18885 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.,

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 6 -29 26.12

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Von Hagel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24 1856

8. AGE: Years	Months	Days	If less than one day
88	5	14	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Oliver

13. Birthplace Md.

MOTHER 14. Maiden Name Emily Durham

15. Birthplace Md

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.,

17 (a) Burial, cremation, or removal (b) Date thereof 7/12/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Brooklyn Md

18 (a) Funeral director 219 N. Pond St

(b) Address Baltimore, Md.

19 VH 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1944, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1943 to 7/8 1944, and that I last saw her alive on 7/8 1944.

Immediate cause of death	Duration
Bronchopneumonia	?
Due to HCVD	?
Lt. hemiplegia	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M.D.

Address 13 E 4 Date signed 7/0

G18886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered G18886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3751 Elm Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3751 Elm Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John McLane James.

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-5376

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Sarah E. James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1877

8. AGE: Years 67 | Months - | Days 23 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Pilot.
11. Industry or business Exempt Fireman

FATHER 12. Name Wm. V. T. James
13. Birthplace Maryland.

MOTHER 14. Maiden Name Ruth ?
15. Birthplace Maryland.

16 (a) Informant Robert M. James
(b) Address 3751 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Leonard Bros Funeral Home
(b) Address 3615-17 Eastern Ave

19 JUL 11 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to July 7 1944, and that I last saw h. l. M alive on July 7 1944.

Immediate cause of death: Carcinoma Stomach — Duration 1943.
Due to: Left Cerebral Hemorrhage — 7/7/44.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. N. Nelson M. D.
Address 617 W. 40th St Date signed 7/8/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C18887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. C18887

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3632 Malden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3632 Malden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stella P. Hubbs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married.

6 (b) Name of husband or wife Raymond Hubbs.
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) April 5, 1903

8. AGE: Years	Months	Days	If less than one day
41	3	3	hr. min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Luther Bell
13. Birthplace Virginia.

MOTHER
14. Maiden Name Clara Bell.
15. Birthplace Virginia

16 (a) Informant Raymond Hubbs.
(b) Address 3632 malden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11/44 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City, Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

JUL 11 1944 Washington Baltimore MD
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous.

Due to Hypertensive Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fretwell M.D.
Medical Examiner.
Date signed July 8 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G18888 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 W 33rd St.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 W 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Carr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-9936

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Clara Carr

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1915

8. AGE: Years 28 | Months 9 | Days - | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Inspector.

11. Industry or business Bleachy Plant.

FATHER
12. Name Wm. E. Carr.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Evelyn Whitmister
15. Birthplace Maryland.

16 (a) Informant Mrs. Clara Carr.
(b) Address 405 W 33rd St.

17 (a) Burial (b) Date thereof July 11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ London Park
Location Frederick Road.

18 (a) Funeral director Cromwell & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) JUL 11 1944 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1944, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to July 8 1944, and that I last saw him alive on July 8th 1944.

Immediate cause of death: Sub-Acute Endocarditis — Duration 2 months

Due to

Due to

Other Conditions Pyelonephritis. — 6 months
Not Corrected
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None

23. Signature L. K. Groff M. D.
Address 5106 Harford Rd. Date signed 7-9-44

G18889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G18889 Registered No.

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD ROAD.
(c) Hospital or institution: NURSING HOME. 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1YEAR
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No 3615. ASH STREET. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME PEARL CRUE.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1900

8. AGE: Years 43 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Benjamin F. Crue
13. Birthplace Md.

MOTHER
14. Maiden Name Ella B. Carter
15. Birthplace Md

16 (a) Informant Verna E. Lebold.
(b) Address 3615 Ash St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12/44 (month) (day) (year)
(c) Cemetery or crematory Fork
Location Baltimore Co. Md.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615 Ash St.

19 JUL 11 1944 (Date rec'd by registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH JULY 10. 1944 at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 8 1944 to JULY 10 1944 and that I last saw her alive on JULY 10 1944.

	Duration
Immediate cause of death ACUTE CARDIAC DILITATION JULY 8. 194	
Due to CHRONIC INTERSTIAL NEPTHRITIS	1944.
Due to EPILEPSY (CONVULSIONS)	1914.
Other Conditions SPASTIC PARALYSIS RIGHT SIDE. (Include pregnancy within 3 months of death)	1914

Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. P. Clautice Jr. M.D.
Address 3013 SAINT PAUL STREET Date signed JULY 10

G18890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

Registered No. G18890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Bon seCours Hospital
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-1
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State W.Va. (b) County
(c) City or town Milton (Rural) (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lessie Olive King

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William B.King
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 7,1892

8. AGE: Years	Months	Days	If less than one day
51 52	7	5	hr. min.

9. Birthplace Barbersville,W.Va. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Thomas J. Gothard
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Algeo
15. Birthplace W.Va.

16 (a) Informant Miss Olive King
(b) Address 3112 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)
(c) Cemetery or crematory Milton
Location Milton, W. Va.

18 (a) Funeral director Frederick A. Cook
(b) Address 1 Mon Lombard St.

19 7 11 1944 (Date received by Registrar) (b) Huntington, W. Va.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1944 at 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1944 to 7/10 1944 and that I last saw her alive on 7/10 1944.

Immediate cause of death Pulmonary Embolus — Duration

Due to — Duration

Due to — Duration

Other Conditions Diffuse Leiomyomata Uteri, Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation 6/27/44

Major findings of operation: Cystocel & Rectocel

of autopsy: Same

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Raymond Long M.D.
Address Huntington, W.Va. Date signed 7/12/44

G18891 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. [redacted] G18891

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 McCulloh St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Mendes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Virgie B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1880

8. AGE: Years 63 64 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Cape Verde Island (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name John Mendes
13. Birthplace Cape Verde Island

MOTHER
14. Maiden Name Mary ?
15. Birthplace Cape Verde Island

16 (a) Informant Virgie Mendes
(b) Address 1944 Lanvale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balt. Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) JUL 11 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944, to July 7 1944, and that I last saw him alive on July 7 1944.

Immediate cause of death: Carcinoma of the Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Carpenter Jr. Provident Hospital Date signed 7/11/44

[redacted] G18892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G18892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 04.
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 W. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lettie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1870

8. AGE: Years 74 | Months - | Days 8 | If less than one day hr. min.

9. Birthplace Anne Arundel County, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lillian Wainwright
(b) Address 541 W. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-44 (month) (day) (year)
(c) Cemetery or crematory Furnace Branch
Location Anne Arundel Co. Md.

18 (a) Funeral director Francis H. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JUL 1 1944 (Date received by registrar) [illegible]

MEDICAL CERTIFICATION 30

20. DATE OF DEATH July 9 1944 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral embolism
Cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 9 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1135 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luceille Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1890

8. AGE: Years	Months	Days	If less than one day
53	10	28	hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant M's Sarah Jackson
(b) Address 1031 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JUL 11 1944 (Date received) (b) Registrar, M. C. Address

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 8, 1944 19 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 19 44 to July 8 19 44 and that I last saw h[illegible] alive on July 8 19 44.

Immediate cause of death	Duration
Nephrocalculosis	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 754 Eutaw Date signed 7/11/44

G18894 [redacted] G18894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 558

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Argyle Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Argyle av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma F. Martin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/1876
8. AGE: Years 67 | Months 8 | Days | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Teacher (retired)
11. Industry or business

FATHER
12. Name John W. Martin
13. Birthplace md

MOTHER
14. Maiden Name Rebecca Honeryeon
15. Birthplace md.

16 (a) Informant Mrs Nellie Thomas
(b) Address 1208 argyle av
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem. Co.
Location A.A. Co., Md.
18 (a) Funeral director Mrs Frances A. Hundley
(b) Address 578 N. Beddle st
19 (a) (Date rec'd by registrar) (b) [illegible], Registrar

JUL 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th 1944 at 7:31 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1943 to July 8 1944, and that I last saw h. alive on July 8 1944

Immediate cause of death: Carcinoma

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Heatley M. D.
Address 1200 Druid Hill Ave Date signed 7/10/44

G18895 [redacted] G18895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. [redacted]

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (Govens) Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Anne Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name John Albright
13. Birthplace N. C.

MOTHER: 14. Maiden Name Alice Adams
15. Birthplace N. C.

16 (a) Informant John W. Thomas.
(b) Address 1209 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St

19 (a) [illegible] 11 1944 (Date received by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, '44 19 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to July 4 1944 and that I last saw her alive on July 4 1944

Immediate cause of death	Duration
Septicemia	
Due to Osteomyelitis	
Due to Surgical Operation (rel)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature C. Mansell Lawrence M. D.
Address 1033 W. Lanvale St. Date signed 7/10/44

G18896 [redacted]

AB-88829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 b

[redacted] G18896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Fisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Little

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5366

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15-1907

8. AGE: Years	Months	Days	If less than one day
36 37	8	15 2	3 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Bagage Porter

11. Industry or business Hotel

FATHER
12. Name Edward Little (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Annie McCreer
15. Birthplace Md.

16. (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Baltimore Co. Md.

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

19 (a) JUL 11 1944 (date signed) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 9.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4 1944, to 7/8 1944, and that I last saw him alive on 7/8 1944.

Immediate cause of death	Duration
Pulmonary TBC	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Sigman M. D.
Address BCH Date signed 7/10

G18897 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

168 Registered No. G18897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isadore Pomerantz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace NOT KNOWN (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name NOT KNOWN
13. Birthplace ?

MOTHER 14. Maiden Name NOT KNOWN
15. Birthplace ?

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-11-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO + CONKLIN STS

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) JUL 11 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944 at 2 15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 7 1944 M.
(b) Where did injury occur? Baltimore St & Guilford Ave
(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? no
(d) Means of injury Blunt force

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 7 1944

Thurston Williams, M.D.

G18898 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

[redacted] Registered No. G18898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Caulendar Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 123 Route 15 Middle River
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1944

8. AGE: Years | Months | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name Frank Brush
13. Birthplace Baltimore

MOTHER
14. Maiden Name Gertrude Cohanowich
15. Birthplace Baltimore

16 (a) Informant mother
(b) Address Box 123 Route 15, Middle River

17 (a) Burial (b) Date thereof 7 11 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto Co Md

18 (a) Funeral director Frances Burgdorfer
(b) Address 1407 Eastern Ave Rd

19 (a) [redacted] 11 1944 [redacted]
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death	Duration
Aspiration Pneumonia	
Due to Regurgitation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Dr. [illegible], Dr. [illegible]

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond B. Hartberg
Address Sinai Hosp. Date signed 7/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

[redacted] GI8899

YA-88883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

[redacted] Registered No. GI8899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N. Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mace Ray

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1871

8. AGE: Years	Months	Days	If less than one day
72	6	14	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Adam Ray
13. Birthplace N. C.
14. Maiden Name Isabelle ?
15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) JUL 11 1944 (b) Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1944, to 7/9 1944, and that I last saw h[redacted] alive on 7/9 1944.

Immediate cause of death: Bronchopneumonia — Duration: 2
Due to: Carcinoma of stomach — ?
Due to:
Other Conditions: Cachexia, malnutrition
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Sergeant M. D.
Address BCH Date signed 7/10

G18900 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a [redacted] G18900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 N. Kenwood Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Kenwood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAAMI E. BECKER

3 (b) If veteran, name war ———
3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Becker
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 16, 1871

8. AGE: Years	Months	Days	If less than one day
73	1	23	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name William Jenkins
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margarete Sommers
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William Becker
(b) Address 515 N. Kenwood Ave.,

17 (a) Burial (b) Date thereof 7/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS JUL 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1944, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944 to July 3 1944, and that I last saw h[illegible] alive on July 3 1944.

Immediate cause of death	Duration
myocardial insufficiency	1 day
Due to cerebral hemorrhage left hemiplegia	4 days
Due to hypertension, chr. nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Sobihal M.D.
Address 447 N. Kenwood Ave. Date signed 7/10/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G18901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B Register G18901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Walbrad Ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Edward Lee Doyle Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret Burns
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Feb. 20 92
8. AGE: Years 52 | Months 4 | Days 20 | If less than one day ... hr. ... min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Electrician
11. Industry or business B. & O.

FATHER
12. Name James Doyle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Henry
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret B. Doyle
(b) Address 4106 Walbrad Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.
19 JUL 11 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1944 at 5 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1944 to 7/10 1944 and that I last saw h[illegible] alive on 7/10 1944.

Immediate cause of death: Peritonitis — Duration
Due to, or as a consequence of: Perforated Duodenal Ulcer —
Due to, or as a consequence of: Strangulated Ing —
Other Conditions Uremia —
(Include pregnancy within three months of death)
Date of operation 7-9-44
Major findings of operation: Peritonitis, Perforated Ulcer, Strangulated
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged primarily.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —
23. Signature V. L. Raffucci M.D. M. D.
Address — Date signed 7/10/44

G18902 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 N [redacted]

G18902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. 23-1
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 S. Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Hooper

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Cold	Married

6 (b) Name of husband or wife Emma A. Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 - 1863

8. AGE: Years	Months	Days	If less than one day
80	11 9	20	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Hooper
13. Birthplace md

MOTHER
14. Maiden Name Caroline Wilson
15. Birthplace md

16 (a) Informant Samuel J. Hooper
(b) Address 1220 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 - 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Hoffman St

19 (a) (Signature of registrar) (b) Registrar

JUL 11 1944 Hamilton Station, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1944, to July 8 1944, and that I last saw h[illegible] alive on July 8 1944.

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Lubeto M.D.
Address 1213 Light St. Date signed 7/8/44

G18903 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

[redacted] Registered No. G18903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2437 E. Federal St
(c) Hospital or institution:

8-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 E. Federal St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Schammel.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura E. Schammel
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) February 22, 1892

8. AGE: Years	Months	Days	If less than one day
52	4	18	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Deputy Tax Collector
11. Industry or business Internal Revenue

FATHER
12. Name Lorenzo F. Schammel
13. Birthplace Baltimore Maryland.

MOTHER
14. Maiden Name Elizabeth Mell
15. Birthplace Baltimore Md.

16 (a) Informant Laura E. Schammel (wife)
(b) Address 2487 E. Federal St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Batty. Cem.
Location North Ave.

18 (a) Funeral director Wm. C. Miller & Sons
(b) Address 2425 E. Oliver St.

19 (a) (Date received by registrar) (b) Registrar

JUL 11 19[illegible] [illegible] Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944, at 2:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944, to July 10 1944, and that I last saw her alive on July 10 1944

Immediate cause of death	Duration
Angina Pectoris	
Arterio Sclerosis Coronary Artery	6 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation?
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. F. A. Stevens M. D.
Address 2878 Hartford Rd Date signed 7-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18904 [redacted] G18904

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92N

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 E Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 E Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Anna Germaty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Herman J. Germaty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8 1863

8. AGE: Years 81 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Miss Elizabeth Germaty
(b) Address 2123 E Federal St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-11-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Baltimore
John E Miller Funeral Director

18 (a) Funeral director [redacted]
(b) Address [redacted]

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 8 1944 and that I last saw her alive on July 8 1944

The immediate cause of death
Cardiac Dilatation — Duration 3 Days
Due to Aortic Insufficiency and Arteriosclerosis — 3 Yrs.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg M.D.
Address 2026 E Monument St Date signed 7/10/44

VS 150

G[redacted]

8905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 N

Registered No. G18905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1449 Ward st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1449 Ward st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1892

8. AGE: Years 51 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home —

11. Industry or business

MOTHER | FATHER
12. Name Thomas Cornish
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Martha Dempsey
15. Birthplace Baltimore Md

16 (a) Informant Elizabeth Cornish
(b) Address 1449 Ward —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) Filed July 11 1944 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1944 at 4 57 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1944 to July 7 1944 and that I last saw h[illegible] alive on July 6 1944

Immediate cause of death Chronic Myocarditis

Due to Hypertension

Due to Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Frankel M. D.
Address 1 W C Lee Date signed 7/10/44

VS 3

G18906 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

[redacted] Registered No. G18906

MARK "X" IN RESERVED FOR LANDING. Every item of information should be carefully answered. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5111 Wolverton Ave.
(c) Hospital or institution:
27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5111 Wolverton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Santom

3 (b) If veteran, name war -------
3 (c) Social Security Account No. 214-18-1520

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Geraldine Santom
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1876

8. AGE: Years 67 | Months 10 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Cleveland Ohio (Town, county, and state)
10. Usual Occupation Theathre Business
11. Industry or business

FATHER
12. Name William Henry Santom
13. Birthplace Akron Ohio

MOTHER
14. Maiden Name Viola Young
15. Birthplace New Orleans

16 (a) Informant Geraldine Santom
(b) Address 5511 Wolverton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Emmart Armcost
(b) Address 3911 Liberty Heights Ave.

(a) [illegible] (Registrar) (b) ..... Registrar

JUL 11 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944 at 10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 7/1 1944 to 7/9 1944 and that I last saw h. [illegible] alive on 7/9 1944.

Immediate cause of death Coronary Thrombosis — Duration Sudden
Due to Arteriosclerotic C.V. D. — Duration ?
Due to R. Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 506 E. Preston Date signed 7/10/44

G18907 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248 Registered No. G18907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Philip Neri Correoso

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Marguerite L. Correoso

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 28 1874

8. AGE: Years	Months	Days	If less than one day
70	1	10	hr. — min.

9. Birthplace Kingston, Jamaica, B.W.I. (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business Retired

FATHER
12. Name Philip Neri Correoso
13. Birthplace Jamaica

MOTHER
14. Maiden Name Elizabeth McCaw
15. Birthplace Jamaica

16 (a) Informant Philip Neri Correoso
(b) Address 1810 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Lichtner & Son
(b) Address Balto., Md.

19 (a) [illegible] (b) [illegible] 1944 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to July 8 1944, and that I last saw him alive on July 8 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Portal Cirrhosis	7
Due to	
Other Conditions Ascites	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Ellsworth Roh M.D.
Address Mercy Hospital Date signed 7-8-44

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 018908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 140 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Holland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1893

8. AGE: Years 51 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bob Steel
13. Birthplace S. Carolina

MOTHER
14. Maiden Name
15. Birthplace unknown

16 (a) Informant George Holland
(b) Address 140 N. Eutaw St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 12/44 (month) (day) (year)
(c) Cemetery or crematory
Location Conway S. Carolina

18 (a) Funeral director Mrs. Robert A. Ellwood
(b) Address 1129 N. Carolina St.

19 (a) JUL 11 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1944 to July 9 1944, and that I last saw h[illegible] alive on July 9th 1944.

Immediate cause of death: Bronchopneumonia — Duration

Due to:

Due to:

Other Conditions: Nephritis. arterio-sclerosis & Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary A. Davis M. D.

Address 118 D'Orsay St. Date signed July 11th 1944

G18909 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G18909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gramercy Apartments
(c) Hospital or institution: 5002 Bel Baltimore (27) Frederick Rd 28

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Arnold Manor (If outside city or town limits, write RURAL and give town)
(d) Street No. 744 Baltimore Rd (If rural give location)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 1½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs 1 mo 19 da
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Montgomery G. McCay

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1867

8. AGE: Years	Months	Days	If less than one day
77	1	19	1 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Dairy
11. Industry or business

FATHER
12. Name J. P. McCay
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emily May
15. Birthplace Md

16 (a) Informant Dr. A. J. Gunning
(b) Address 5202 Frederick Rd., City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 1944 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md
18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Richards
19 (a) Date received July 11 1944 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 44, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 19 35, to July 10 19 44, and that I last saw h[illegible] alive on 7/10 19 44.

Immediate cause of death Coronary Occlusion	Duration
Due to Acute Pulmonary Edema	3 days
Due to Chronic Heart Disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Montgomery J. Gunning M. D.
Address 7/10 5202 Frederick Rd Date signed 7/10/44

VS 3

[redacted] G18910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. [redacted] G18910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland – 23
(b) Street address 528 Poplar Gr. St.
(c) Hospital or institution: Grove 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore – 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Poplar St. (If rural route, give number) Grove
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME William A. (Osborne) – Osborn

3 (b) If veteran, name war —

3 (c) Social Security Account No. 155-07-3970

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary E. Osborn (nee Kenton)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1871

8. AGE: Years 72 | Months 9 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Middleton & Meade

FATHER
12. Name Wister W. Osborn
13. Birthplace Pa.

MOTHER
14. Maiden Name Elanor Costello
15. Birthplace Pa.

16 (a) Informant Charles W. Osborn (Son)
(b) Address 528 Poplar Grove St. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Locust-wood Cem.
Location Marlton Pike, Ellisburg, Camden Co. N.J.

18 (a) Funeral director A. Howard Evans
(b) Address 1400-02 S. Charles St. Balto 21 Md.

19 (a) JUL 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1944 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to July 10 1944 and that I last saw him alive on July 9 1944

Immediate cause of death: Coronary thrombosis. — Duration 4 days

Due to: Arteriosclerotic type of heart disease with congestive failure — Duration —

Due to: Generalized arteriosclerosis — Duration —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place, While at work? (Specify type of place)
(e) Means of injury —

23. Signature L. D. Driscoll M.D.

Address 2401 Eutaw Pl. Date signed July 12 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 18911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9304 Registered No. G18911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied by the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Rectory Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Rectory Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Thomas Fisher

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Imalinda C. Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1st 1858

8. AGE: Years	Months	Days	If less than one day
85	7	10	hr. min.

9. Birthplace Carroll County Md (Town, county and state)
10. Usual Occupation Retired Farmer
11. Industry or business

FATHER
12. Name William Fisher
13. Birthplace Westminster Md.

MOTHER
14. Maiden Name Susan Coker
15. Birthplace Maryland

16 (a) Informant Lillian Agnes Fisher
(b) Address 1015 Rectory Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14/1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director George L. Schwartz
(b) Address 2101 Frederick ave.

JUL 12 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1944, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D. (Medical Examiner.)
Date signed July 11, 1944.

VS 151

G18912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V H6E

G18912 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & CaLvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Douglaston Long Island (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Ridge Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John Turner BINFORD

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Electra B. Binford
6 (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) 6-27-1894
8. AGE: Years 50 Months - Days 13 If less than one day ____ hr. 14 min.
9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation Telephone ENGINEER
11. Industry or business A. T. & T. Co., N. Y.

FATHER
12. Name John G. BINFORD
13. Birthplace VIRGINIA (Richmond)

MOTHER
14. Maiden Name LENORE TURNER
15. Birthplace Virginia

16 (a) Informant admission history
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 13 - 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore City, Md.
18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Av. (W.F. Wooden-Suc.)
19 (a) JUL 12 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11 1944, at 12 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1944, to 7-11 1944, and that I last saw him alive on 7-11 1944

Immediate cause of death: CARDIO-RESP. FAILURE — Duration
Due to: Metastatic CARCINOMA
Due to: CARCINOMA of Sigmoid Colon & Rectum
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill III M. D.
Address Union Memorial Hosp. Date signed 7-11-44

618913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 d

Registered No. 618913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Baltimore - Md
(b) Street address — 700 West 40th St
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) — 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State — Maryland (b) County — Baltimore
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 700 W. 40th St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME — James Arthur Bradley

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife — Sallie Beth Bradley
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) — 9 | 9 | 1881

8. AGE: Years	Months	Days	If less than one day
62	10	2	..... hr. ..... min.

9. Birthplace — Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name — James Bradley
13. Birthplace — Maryland

MOTHER
14. Maiden Name — Josephine Davis
15. Birthplace — Maryland

16 (a) Informant — Emily Bachtel R.N.
(b) Address — Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof — 7-12-44 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location — Charlestown Md.

18 (a) Funeral director — Stewart & Mowbray
(b) Address — 1081 W. North Ave.

19 JUL 12 1944 (Date rec'd by Registrar) (b) Burial Permit No. — Baltimore, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH — July 11th 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940, to July 11th 1944, and that I last saw him alive on July 11th 1944.

Immediate cause of death — Acute Myocardial Insufficiency — Duration 5 mins.
Due to — Arteriosclerotic Cardio-Vascular Disease
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature — Thomas Connors M.D.
Address — 11 E. Chase St. Balto. Md. Date signed — 7/11/44

G18914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G18914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Fawn St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Italy.

3 (a) FULL NAME Catherine Orienti

3 (b) If veteran, name war none. | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Gus Orienti

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1854

8. AGE: Years 90 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Italy. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony Cuneo.
13. Birthplace Italy.

MOTHER 14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Joseph Schnetti
(b) Address 1010 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Irvington Road

18 (a) Funeral director Mendell & Skeppel
(b) Address 512 S. Highland Ave.

19 ([redacted]) 19[redacted] (b)

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to July 10 1944 and that I last saw h[redacted] alive on July 10 1944

Immediate cause of death	Duration
(a) Senile Myocardial Failure	
Due to	
Due to Arterio-Sclerosis	2 y.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. L. Valentine M.D.
Address 1010 Fawn St. Date signed July 12 1944

Thanks for Assistance

G18915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No.

G18915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Walnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Walnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie B. Quillian

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife late Laban T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1866

8. AGE: Years	Months	Days	If less than one day
78	5	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Emory T. Bell
13. Birthplace Md.
14. Maiden Name Henrietta Taylor
15. Birthplace Md

16 (a) Informant Robert D. Case Sr.
(b) Address 804 walnut ave.

17 (a) Buried (b) Date thereof 7-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Buckingham
Location Berlin Md

18 (a) Funeral director Harry A. Wilkins
(b) Address 1101 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to July 10 1944, and that I last saw h alive on July 9 1944.

Immediate cause of death Uremia, Oedema — Duration 2 days

Due to Renal Insufficiency
Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo F Block M. D.
Address 20 E Preston Date signed 7/11/44

VS 150

G18916 — BALTIMORE CITY HEALTH DEPARTMENT — G18916

CERTIFICATE OF DEATH

552 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2551 Frederick Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace H Schmidt.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Victor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/1888

8. AGE: Years 56 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name — Darby.

13. Birthplace —

MOTHER — 14. Maiden Name —

15. Birthplace —

16 (a) Informant Victor Schmidt

(b) Address 2551 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director H Wyke

(b) Address 410 Edmondson Ave

19 (a) (b) (Signature of registrar)

JUL 12 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/9 1944, and that I last saw h[illegible] alive on 7/8 1944.

	Duration
Immediate cause of death: Lymphatic Sarcoma left groin	1 yr.
Due to —	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M. D.

Address 1206 E. Preston St Date signed 7/11/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C18917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C18917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Walbert Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No.: Walbert Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM EMORY WARING JOHNS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nina Scott Johns
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1875

8. AGE: Years: 68 | Months: 9 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Joseph Johns, Jr.
13. Birthplace: Md.

MOTHER
14. Maiden Name: Susan Waring
15. Birthplace: Md.

16 (a) Informant: Mr. T. Parkin Scott, Sr.
(b) Address: 1524 Rolling Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/13/44 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

Date received by Registrar: JUL 12 1944 Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10, 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1943 to July 11 1944 and that I last saw him alive on July 10 1944

Immediate cause of death: Cardiovascular Renal Disease — Duration: years

Due to:

Due to:

Other Conditions: Chronic Arteritis — Duration: years

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Nathaniel M Beck M.D.
Address: 2727 N Charles Date signed: July 11 44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G18918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G18918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEWIS K. SOHL

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bessie Florence
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug. 7, 1874
8. AGE: Years: 69 Months: 11 Days: 3 If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Printer
11. Industry or business: Sun Printing Co.

FATHER
12. Name: J. Adam Sohl
13. Birthplace: Md.

MOTHER
14. Maiden Name: Margaret Rauderer
15. Birthplace: Md.

16 (a) Informant: Mrs. Bessie F. Sohl
(b) Address: 2208 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

JUL 12 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH July 10, 1944, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to July 10 1944, and that I last saw living on July 10 1944.

Immediate cause of death: Myocarditis — Duration:
Due to: Arterio Sclerosis
Due to: Hypostatic Pneumonia
Other Conditions: -

(Include pregnancy within 3 months of death)
Date of operation: -
Major findings of operation: -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jno E Whitehill M. D.
Address 230 E. Mnor Pkwy Date signed 7/11/44

G18919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

168

Registered No. G18919

Every item of information should be given. Please write plainly, with UNFADING INK. Even if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Forman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/22/1901

8. AGE: Years 43 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace N. C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Green Taylor
13. Birthplace N. C.

MOTHER
14. Maiden Name Estella Colmen
15. Birthplace N. C.

16 (a) Informant Helen Austin
(b) Address 1102 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)
(c) Cemetery or crematory Fredericksburg Va
Location

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pratt Market

19 (a) JUL 12 1944 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8- 19KK, at 10 40 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-7- at P. M.
(b) Where did injury occur? 1831 Forman St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ignited kerosene
Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-11-44

VS 151

G18920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 9a

G18920 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 E 30th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 E. 30th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. HORSTSCHNEIDER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-0364

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife George T. Horstschneider

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/24/1887

8. AGE: Years 6 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Vice-president

11. Industry or business Drugs.

FATHER
12. Name Joseph Long
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary C. Bauer
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Alma Wildberger
(b) Address 1726 E. 30th St

17 (a) Burial (b) Date thereof 7/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) 7-12-1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1943 to July 11 1944, and that I last saw h[illegible] alive on July 11 1944.

Immediate cause of death	Duration
Cachexia -	
Fecal carcinomatosis	9 mo.
Due to	
edema - carcinoma of	
Due to left ovary.	1 yrs.
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Schlink M.D.

Address 447 N. Kenwood Ave Date signed 7/11/44

G18921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G18921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 St Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Abbey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of ~~husband~~ wife Kate Abbey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/66

8. AGE: 78 Years | 4 Months | 25 Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name William Abbey

13. Birthplace Baltimore Md.

14. Maiden Name Jane Spedden

15. Birthplace Cambridge Md.

16 (a) Informant Pauline Watkins

(b) Address 3506 Harmon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) JUL 12 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11 1944 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1944 to 7/10 1944 and that I last saw ~~him~~ alive on 7/10 1944

Immediate cause of death: Prob. Coronary Thrombosis — Duration

Due to Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify one or place)
(e) Means of injury

23. Signature R. M. U. Crosby M.D.

Address Mercy Hospital Date signed 7/11

G18922

JL - 88901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G18922 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Hudson St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette Emmerick

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1896

8. AGE: Years 47 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Gamble
13. Birthplace Germany

MOTHER
14. Maiden Name Cynthia ?
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-14-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director John F. Riegel
(b) Address 2829 Hudson St.

(a) Huntington Williams M.D.
JUL 12 1944 (Date received) (By) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-10 1944, at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1944, to 7-10 1944, and that I last saw her alive on 7-10 1944.

Immediate cause of death	Duration
Cachexia	1 yr.
Due to Carcinoma Cervix	?
& Metastases	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 7-11-44

G18923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

G18923
Registered No.

MARGINS RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Ruscombe Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara X Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Stanley Hooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1866

8. AGE: Years 78 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Michael Coyne
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Feeney
15. Birthplace Ireland

16 (a) Informant Mrs Eleanor Reitz
(b) Address 2807 Ruscombe Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City

18 (a) Funeral director C. Vernon Leatherman
(b) Address 611 Park Heights Ave

19 JUL 12 1944 (Date rec'd by registrar) (b) Huntington Mills Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to July 8 1944, and that I last saw her alive on July 8 1944.

Immediate cause of death Shock — Duration 18 hrs.

Due to Cardiac failure — 8 mos

Due to Chronic myocarditis — 10-20 yrs.

Due to Hypertension Cardio-vascular disease

Other Conditions Partial obstruction of colon due to Ca of Cecum.
(Include pregnancy within 3 months of death)

Date of operation June 6 1944

Major findings of operation: Abscess of abdominal wall + suppurative peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Jesse Berry, M.D.
Address Mercy Hospital Date signed 7/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G18924
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Woodland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME G. Dennis Harper

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Matie Harper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1855

8. AGE: Years 89 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER
12. Name Francis Harper
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Donoghue
15. Birthplace Washington, DC

16 (a) Informant Md. General Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore County, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] (b)
[illegible] Registrar

JUL 12 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944, at 10.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10-44 19- to 7-9-44 19, and that I last saw h/m alive on 7/9 1944.

Immediate cause of death: Chronic myocarditis — Duration: years
Due to Arteriosclerosis + senility
Due to
Other Conditions Prostatic adenoma "

(Include pregnancy within 3 months of death)
Date of operation 6-13-44
Major findings of operation: Adenomyo-ma of prostate.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Traynor M. D.
Address Md. General Hosp. Date signed 7/9/44

G18925 Rowe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 East 23rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 East 23rd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Lola Rowe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Herbert A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1892
8. AGE: Years 52 | Months — | Days — | If less than one day hr. min.
9. Birthplace: Charles Co. Md. (Town, county, and state)
10. Usual Occupation: At Home.
11. Industry or business:

FATHER
12. Name: Peter H. Roby
13. Birthplace: Charles Co., Md.

MOTHER
14. Maiden Name: Elizabeth C. Mattox
15. Birthplace: Charles Co., Md.

16 (a) Informant: Mr. Herbert A. Rowe
(b) Address: 508 E. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/44 (month) (day) (year)
(c) Cemetery or crematory: St. Thomas Manor
Location: Charles Co., Md.

18 (a) Funeral director: Lester Weyforth
(b) Address: 500 E. 20th St.

19 (a) JUL 12 1944 (Date received by Registrar) (b) Huntingtown, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/44 19 , at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1943 to July 11 1944. and that I last saw her alive on July 11 1944.

Immediate cause of death	Duration
Cardiovascular Collapse	
Due to advanced Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E. Monument Date signed 7-12-44 M. D.

G18926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G18926
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40th & Kenwick Rd.
(c) Hospital or institution:
Home for Incurables.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 7-9-15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40th St. & Kenwick Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Mrs. Mary Elizabeth Atwood

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Albert H. Atwood
6 (c) If alive, give age 86 years
7. Birth date of deceased (mo., day, yr.) Sept. 25-1865.

8. AGE: Years	Months	Days	If less than one day
78 yrs	9 mos	15 days	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Charles Rogers
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. Reister
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. E. M. Taylor (niece).
(b) Address 1609 St. Paul St. Baltimore, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.
18 (a) Funeral director Charles C. Stamp
(b) Address 5701 Rock Spring Road.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 5

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944, at 11:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1938 to July 10 1944 and that I last saw h[er] alive on 19

Immediate cause of death	Duration
Acute Myocardial Insufficiency	1 week
Due to Generalized Arteriosclerotic Cardio-Vascular Disease	10 years
Due to Widespread Decubitus Ulceration	4 months 9 years
Other Conditions Multiple Atrophic Bullae	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas Command M.D.
Address 11 E. Chase St. Baltimore 18 Date signed 7/11/44 (M.D.)

JUL 12 1944 Huntington Williams, M.D. Registrar

G18927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

G18927
Registered No.

MARK IN RESERVED FOR ENDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Brendan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Brendan Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Peter H. Haeffner

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-16-3761

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Theresa E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1866

8. AGE: Years	Months	Days	If less than one day
78	4	16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Jones Costumers

FATHER
12. Name Dennis J Haeffner
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Lawerance C. Haeffner
(b) Address 3017 Brendan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944 at 7 46a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4th 1944 to July 11 1944, and that I last saw alive on July 10 1944.

Immediate cause of death	Duration
Broncho Pneumonia	3d.
Due to Cerebral Hemorrhage	7 wks
Due to Arterio Sclerosis	7 mos
Other Conditions Chr. Interstitial Nephritis	7 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos F A Stearns M. D.
Address 2878 Harford Rd Date signed 7-11-44

G18928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 744a

G18928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3915 Belview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Koppel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Wh. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sam. —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Hyman Mazur
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie —
15. Birthplace Russia

16 (a) Informant Bernard Mazur
(b) Address 1622 Gwynns Falls Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Lisedale
Location Phil. Pa.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (b) Registrar

(Date rec'd by Reg.) JUL 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12/1944 at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3/1944 to 7/12/1944 and that I last saw her alive on 7/12/1944.

Immediate cause of death Cardiac failure — Duration

Due to Pneumonia

Due to Leukemia (lymphatic)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Leukemia + Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Rinaldes M.D.
Address Sinai Hosp Date signed 7/12

Huntington Williams M.D.

G18929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 d

G18929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. 108 W. 24th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Zitelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name Charles

13. Birthplace R.

MOTHER 14. Maiden Name Clara

15. Birthplace R.

16 (a) Informant Rebecca Zitelman

(b) Address 108 W. 24th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-44 (month) (day) (year)

(c) Cemetery or crematory Shaarie

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1409 E. Balto. St

19 (a) JUL 12 1944 (Date of this registration)

Huntington Ave Baltimore Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1944, at 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944, to 7/10 1944, and that I last saw him alive on 7/10 1944.

Immediate cause of death: Myocardial insufficiency — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm. edema. Arteriosclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Leonard Aksman M. D.

Address Sinai Hosp. Date signed 7/11/44

Aksman

MAKE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1932 G18930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 SPRING DALE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Spring dale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SLOVIN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: FEMALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Louis -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rubin Jacob Kassin
13. Birthplace Russia

MOTHER
14. Maiden Name Hittel -
15. Birthplace Russia

16 (a) Informant Jacob Sharp
(b) Address 3626 Rid. Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Geo Lewis Inc
(b) Address 1300 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11-44 19 , at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1940 to July 11 1944, and that I last saw h[illegible] alive on July 11-44

Immediate cause of death: Acute Cardiac Dilatation — Duration 1 hr

Due to: Chron Myocarditis Typ

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Bayless M. D.
Address 2040 Eutaw Date signed 7/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G18984 8332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G18931 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-7days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

4-7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Wilkerson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married-Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-11-1878

8. AGE: Years 65 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name Newton Wilkerson
13. Birthplace Va.

MOTHER: 14. Maiden Name Elizabeth Fairfield
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bthantley and

19 (a) [illegible] 12 1944 Huntington Williams, M.D.
(Date received by local registrar) (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9- 1944, at 12.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2-44 1944, to 7-9- 1944, and that I last saw him alive on 7-9- 1944

Immediate cause of death: Uremia — Duration: 1 month

Due to: Benign Prostatic Hypertrophy — 7

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 6-28-44

Major findings of operation: Cystoscopic (confirmatory)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto City Hosp. Date signed 7-11-44

G18932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G18932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Clarkson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto City (If outside city or town limits write RURAL and give town)
(d) Street No. 1422 Clarkson (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Moon

3 (b) If veteran, name war No.
3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William D. Moon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1878

8. AGE: Years 65 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name John F. Norton
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Mary E. Murphey
15. Birthplace Balto. Md.

16 (a) Informant Mrs Lena Krieger
(b) Address 4300 Barrington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 1944 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Govans

18 (a) Funeral director A. Hyland Eilers
(b) Address 1410 W. Lafayette Ave

19 (a) JUL 12 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to July 11 1944.
And that I last saw her alive on July 11 1944

Immediate cause of death Carcinoma — Duration 4 mos
Due to Cardiac end of Stomach
Due to
Other Conditions Nil
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 124 E Clark St Date signed 7/12/44

G18933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

944a

Registered No. G18933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3822 Hudson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Law

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Bertha E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/1895

8. AGE: Years 49 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Oil Treater

11. Industry or business Standard Oil Co

FATHER
12. Name John Law
13. Birthplace Baltimore

MOTHER
14. Maiden Name Katherine Heinlein
15. Birthplace Baltimore

16 (a) Informant Mrs. Evans
(b) Address 3822 Hudson St.

17 (a) Burial (b) Date thereof 7-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

19 JUL 12 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1944, at 10P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature W. J. Wallenmeyer M.D.
Medical Examiner.
Date signed July 11, 1944.

G18934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G18934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE NO ENTRY IN SPACE RESERVED FOR HEADING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Catherine Umpleby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 25, 1852

8. AGE: Years	Months	Days	If less than one day
92	2	26	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Gallagher
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. George H. Umpleby
(b) Address 2425 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15-44 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Leonard Keyser
(b) Address 5805 Harford Rd Hamilton Station Baltimore, Md.

19 (a) (b) JUL 12 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11- 1944 at 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24/ 1944 to 7/11/ 1944 and that I last saw her alive on 7/11 1944

Immediate cause of death Myocardial insufficiency - Duration 48 hrs.

Due to Cardio-renal-vascular disease 14 -

Due to Senility -

Other Conditions Fractured rt hip 4/24/44 Discharged hospital 6/4/44.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4/24/44 at a. M
(c) Where did injury occur? Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped on floor while walking.

23. Signature Geo. H. Bowden
Address 1517 E. North Ave Date signed 7/11/44

Approved by Howard J. Mercer, M.D.

G18935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Reg. G18935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore #16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Carlisle Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Charlotte R. Jacob.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Patient | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5 1864

8. AGE: Years 80 | Months 4 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation None.
11. Industry or business —

FATHER
12. Name Michael Rosenfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Therese Eberlay
15. Birthplace Germany

16 (a) Informant Mrs. M. L. Rosenblatt,
(b) Address 3306 Carlisle Ave

17 (Cremation (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto. Md.

18 (a) Funeral director Chas. Sonnenmoser Son
(b) Address 902 Eutaw Place

19 (a) ... (Date rec'd by registrar) (b) ... (Registrar)

JUL 12 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944, at 6 22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 1944 to 7-10 1944, and that I last saw her alive on 7-10 1944.

Immediate cause of death: Myocardial failure — Duration
Due to Arteriosclerosis
Due to Coronary Thrombosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill III M. D.
Address Union Memorial Hosp. Date signed 7-10-44

G18936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G18936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 6/24/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
Since 6/24/44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Hooperesville.
(If outside city or town limits, write RURAL and give town)
(d) Street No. -- (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY RUARK TRAVERS

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nora Tyler

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1874

8. AGE: Years 69 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Hoopersville, Md. (Town, county, and state)

10. Usual Occupation Fisherman - M.S.

11. Industry or business "

FATHER
12. Name Henry R. Travers
13. Birthplace Hoopersville, Md.

MOTHER
14. Maiden Name Jane ?
15. Birthplace Hoopersville, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13/44 (month) (day) (year)

(c) Cemetery or crematory
Location Cambridge Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) JUL 12 1944 (Date rec'd by registrar) (b) Huntington Mills Registrar Baltimore, Md.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH July 12, 1944, at 6:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24, 1944 to July 12, 1944, and that I last saw him alive on July 12, 1944

Immediate cause of death Cerebral thrombosis, lenticulostriate artery with hemiplegia — Duration Since 6/21/44

Due to Arteriosclerosis — Unk.

Due to

Other Conditions Hypertensive cardio-vascular disease — Unk.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. R. Albinus M. D.
Address Baltimore, Md. Date signed 7/12/44

MB-53747

G18937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G18937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 5303 York Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Florence Richardson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1864

8. AGE: Years 79 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired teacher
11. Industry or business

FATHER
12. Name Benjamin V Richardson
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Martha Dushane
15. Birthplace Balto Md.

16 (a) Informant Hospital records
(b) Address 33rd & Calvert Balto. #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fred. Ave

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar

JUL 12 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944 at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to July 11 1944 and that I last saw her alive on July 11 1944.

Immediate cause of death: Cardio-Resp Failure — Duration

Due to Bilateral Broncho Pneumonia

Due to Hypertensive C-V Disease & Cerebral vascular Accident.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature John D. Morris M. D.
Address Md. Date signed 7-11-44.

G18938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G18938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 N.Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N.Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Dill

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Geo.W.Dill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.18,1868

8. AGE: Years	Months	Days	If less than one day
75	10	22	hr. min.

9. Birthplace Balto.Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Dukehart
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Caroline ---
15. Birthplace Balto.Md.

16 (a) Informant Miss Helen Dill
(b) Address 620 N.Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto.Md.

18 (a) Funeral director Philip Hewitt Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. 2005 E. Monument St

VS JUL 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10.1944 19..., at ...M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940, to July 10 1944, and that I last saw h-- alive on July 7 1944.

Immediate cause of death	Duration
Due to Chron. Myocarditis	5yrs.
Due to Chron. Nephritis	
Other Conditions Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ...M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Frank J Ayd M. D.
Date signed 7/12/44

G18939 G18939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

J L - 82690 138 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 - 24
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Carroll St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry McRae

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Evelyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1899

8. AGE: Years 45 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Yank
13. Birthplace S. C.

MOTHER — 14. Maiden Name Agnes Harriet
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Belnord Ave.

19 (a) (Date rec'd by registrar) (b)

VS JUL 12 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/44 19 , at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12/ 1943 to 7/11 1944, and that I last saw h[illegible] alive on 7/10 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: -

of autopsy: Not done

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. E. H. Date signed 7/11 M D

Address

G18940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G18940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Theresa Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/18/44

8. AGE: Years | Months | Days 2/22 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Baby
11. Industry or business —

FATHER 12. Name Vernon Walker
13. Birthplace Md

MOTHER 14. Maiden Name Bernice Walker
15. Birthplace Md

16 (a) Informant Bernice Walker
(b) Address 713 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-44 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Baltimore Rd. City

18 (a) Funeral director Mrs. Leslie R. Williams
(b) Address 322 N. Belnord Ave

19 (a) (Date rec'd by Registrar) JUL 12 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1944 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1944 to 7/10 1944
and that I last saw h[illegible] alive on 7/10 1944

Immediate cause of death Resp. failure — Duration 8 hrs.
Due to Dehydration — 5 days
Due to Diarrhea & fever to Sat — 5 days
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Alfred T. Nelson M. D.
Address University Hospital Date signed 7/10/44

Huntington Williams M.D.

G18941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 d

Registered No. G18941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Lakewood Ave.
(c) Hospital or institution:
Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Lakewood.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret (nee Powers)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/76

8. AGE: Years	Months	Days	If less than one day
68	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Pa. R. R.

FATHER
12. Name James Ryan
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Daly
15. Birthplace Ireland

16 (a) Informant wife
(b) Address 415 N. Lakewood Avenue

17 (a) Burial (b) Date thereof 7/13/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Registrar

JUL 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1944, at 4:50 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Hypertensive Cardio-vaskular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. Hugh McMullen M.D.
Medical Examiner.
Date signed 7/10/44

G18942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18942 Registered No. 121

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Parkwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eva Garrett

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wilmer H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1886

8. AGE: Years 57 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Mullikin
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Miss Ida M. Garrett
(b) Address 2708 Parkwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) JUL 12 1944 (b) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/44 19 . at 6.35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1944, to 7/11 1944, and that I last saw her alive on 7/4 1944.

Immediate cause of death: Peritonitis — Duration: 5 days
Due to: Ruptured appendix
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 7/8/44
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Md. General Hosp. Date signed 7/11/44

G18943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d R G18943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 Devonshire Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Devonshire Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lola C. Wilders

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edward J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1884

8. AGE: Years 59 | Months 9 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Middletown, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Kefauver
13. Birthplace Md.

MOTHER
14. Maiden Name Emma ?
15. Birthplace Md.

16 (a) Informant Mrs. Ed. J. Wilders
(b) Address 3504 Devonshire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 | 14 | 44 (month) (day) (year)
(c) Cemetery or crematory Middletown Reformed
Location Middletown, Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Baltimore [illegible]

19 (a) (Date rec'd by Registrar) (b) 1944 Registrar

VS 151

MEDICAL CERTIFICATION P.

20. DATE OF DEATH July 11 1944, at 5:05 M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Due to Hypertensive Cardiovascular Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski M.D.
Medical Examiner.
Date signed July 12, 1944

Per: Howard J. Madden, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully determined and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18944

G18944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 18a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2946 Wyman Pky.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rosella R. Buck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 3-1854

8. AGE: Years: 89 yrs. | Months: 10 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER — 12. Name: Dennis Robinson
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Jane Walter
15. Birthplace: Md.

16 (a) Informant: Charles Buck
(b) Address: 2945 Wyman Parkway

17. (a) Burial, cremation, or removal: Greenmount
(b) Date thereof: July 14/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Wyndale Ave.

18 (a) Funeral director: John A. Hoban
(b) Address: 4207 Greenmount Ave
(c) Date rec'd by registrar: JUL 12 1944
(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at 12 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944, to July 11 1944, and that I last saw he/she alive on July 11 1944.

Immediate cause of death: Circulatory failure — Duration 15 hrs.

Due to: Arteriosclerotic heart disease and — 40 yrs.

Due to: Multiple fracture of both legs

Other Conditions: Bilateral fracture of neck of femur and pneumonia

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/6
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: July 10 1944 at M
(c) Where did injury occur? Baltimore (City or town) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell out of bed on floor.
23. Signature: Robert Finn Berry
Address: Mercy Hospital Date signed 7/11/44

VS 160 For D.C.J. Zubowski, by Edward J. Kleinkauf, M.D.

MAKE NO RESERVATIONS FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 737

G18945
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5038 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Merrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
F	W	Single

6 (b) Name of husband or wife Child

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/1940

8. AGE: Years	Months	Days	If less than one day
3	10	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James H. Merrick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret C. Bowen
15. Birthplace Balto. Md.

16 (a) Informant James H. Merrick
(b) Address 5038 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Loring Byers
(b) Address 5005 Reisterstown Rd. Balto. Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1944, at 4:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1944 to 7/12 1944, and that I last saw h[illegible] alive on 7/12 1944.

Immediate cause of death	Duration
Internal hemorrhage, probably into brain-stem	
Due to Blood dyscrasia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Robert Moore, M. D.
Address University Hosp. Date signed 7/12/44

G18946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1472

G18946
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 N. Charles Street
(c) Hospital or institution:
Home - Warrington Apartments
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES BINGHAM PENROSE - 3rd.

3 (b) If veteran, name war: WORLD WAR #1
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Adeline Gibbs Penrose
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) March 25, 1872

8. AGE: Years 72 | Months 3 | Days 16 | If less than one day: hr. min.

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Col. Charles B. Penrose, Jr.
13. Birthplace Carlisle, Pennsylvania.

MOTHER
14. Maiden Name Clara Andaresa
15. Birthplace New York City, N. Y.

16 (a) Informant Mr. Delano Ames (Step - Son)
(b) Address 4809 Keswick Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Green Mount & Oliver Sts., City.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Av. (W. F. Wooden-Suc.)

19 (a) Filed JUL 12 1944 (b) Huntington Nathans, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to July 11 1944, and that I last saw h alive on July 11 1944.

Immediate cause of death: Cancer of Lung — Duration 1 year

Due to: Malignant ponds

Due to:

Other Conditions: Femoral thrombosis

(Include pregnancy within 3 months of death)
Date of operation: Lymph gland
Major findings of operation: Glands Calcified
of autopsy: Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1800 E. Cathedral St Date signed July 14 1944

G18947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

G18947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Dorchester Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Arlington Lee Judefind

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Monnie Judefind
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 - 1864

8. AGE: Years 80 | Months | Days 12 | If less than one day hr. min.

9. Birthplace Kent Co Md.
(Town, county, and state)

10. Usual Occupation Retired Musician

11. Industry or business

FATHER — 12. Name William F. Judefind
13. Birthplace Kent Co. Md

MOTHER — 14. Maiden Name Josephine Harper
15. Birthplace Betterton Md.

16 (a) Informant Mrs. Monnie Judefind
(b) Address 3808 Dorchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Balto City

18 (a) Funeral director Frank E Saltz
(b) Address 814 W 36 St

19 (a) (Date rec'd by registrar) (b) Registrar
JUL 12 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to July 11 1944, and that I last saw him alive on July 11 1944.

Immediate cause of death	Duration
Cardiac respiratory failure	5 hrs.
Due to Coronary Thrombosis.	2 wks.
Due to Arteriosclerotic heart disease	15 yrs.
Other Conditions Benign prostatic hypertrophy + Urinary Frequency	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Zimm Berry M.D.
Address Mercy Hospital Date signed 7/11/44

G18948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18948 Registered No. 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N Eutaw St (If rural give location)
(e) Citizen of foreign country? — na (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie May Hollens

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 21AE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert Gray
13. Birthplace Va

MOTHER 14. Maiden Name Lilly ?
15. Birthplace Va

16 (a) Informant Benjamin Hollens
(b) Address 1101 N. Eutaw St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Co
Location Baltimore, Md

18 (a) Funeral director Wilson Payne
(b) Address 1217 E. Fayette St

JUL 12 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11 1944 at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1944 to 7-11 1944, and that I last saw h[illegible] alive on 7-11 1944.

Immediate cause of death: Cachexia — Duration: 2
Due to: abdominal malignancy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature H. Williams M.D.
Address Md. General Hosp. signed 7/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18949 BALTIMORE CITY HEALTH DEPARTMENT G18949

CERTIFICATE OF DEATH

1644 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 Maple Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minna S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/1890

8. AGE: Years 54 Months 9 Days 17 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Yellow Cab

FATHER 12. Name Robert F. Smith

13. Birthplace Balto Md

MOTHER 14. Maiden Name Pauline Erping

15. Birthplace Balto Md

16 (a) Informant Mrs. Minna Smith

(b) Address 28 Maple Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/44 (month) (day) (year)

(c) Cemetery or crematory London Pk.

Location Frederick Ave

18 (a) Funeral director H. Myers

(b) Address 4101 Edmondson Ave

19 (a) (Deputy) (b) Huntington Williams M.D. Registrar

JUL 13 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Chest.

Suicide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-10-44 at 9:15A M.

(b) Where did injury occur? 28 Maple Drive

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Shot himself with .32 Colt Police pistol

23. Signature J. F. Wolle Medical Examiner M.D.

Date signed July 11, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

G18950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Winans Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Winans Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Welsmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1877

8. AGE: Years 67 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Csolka
13. Birthplace Austria

MOTHER
14. Maiden Name —
15. Birthplace Austria

16 (a) Informant Robert Wildsmann
(b) Address 711 Winans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Weikel
(b) Address 41016 Edmondson Ave

19 (a) JUL 13 1944 (Date received) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944, at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9, 1944 to July 19 1944 and that I last saw h[illegible] alive on July 10, 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 min.

Due to Arteriosclerotic Cardio-Vascular disease — 5 Months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Medical Arts Bldg Date signed 7/12/44

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18951 ✓ 93d G18951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2652 Frederick Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-44
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2652 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Herman Engers, Sr.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-07-1535

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude Engers,

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9/2/1887

8. AGE: Years 57 | Months 11 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business

FATHER
12. Name Charles Engers,
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Gier,
15. Birthplace Baltimore, Maryland.

16 (a) Informant Maude Engers, (wife)
(b) Address 2652 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. Wolfe Street

19 (a) (Date received by Registrar) JUL 13 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JULY 11 1944 at 1/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 43 to Jul 10 1944 and that I last saw h[illegible] alive on Jul 10 1944.

Immediate cause of death	Duration
Acute Cardiac Dilitation	One day
Due to Hypertension Cardiovascular Disease	?
Due to	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fay Stamm M. D.
Address 2677 Madison Date signed 7/12/44

G18952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G18952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 E Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 E Lombard St Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Scheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Scheeler

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Dec 12 1899

8. AGE: Years 44 | Months 5 6 | Days 29 | If less than one day hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Shipping Clerk

11. Industry or business: Furniture

FATHER
12. Name: Charles Scheeler
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Dora Schafer
15. Birthplace: Baltimore

16 (a) Informant: Mrs Margaret Scheeler
(b) Address: 3503 E Lombard St Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: East North Ave

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans St

19 JUL 13 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10/44 19 10 45 pm, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/44 19 to July 3 1944. and that I last saw h[illegible] alive on July 3 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis C. Manieri M. D.

Address 7335 Eastern Date signed 7/11/44

Hunter Jr Williams M.D.

MANIERI

G18953 456978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1330 Registered No. G18953

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Robert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mosse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1891

8. AGE: Years 52 | Months 11 | Days — | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Curry
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Dean
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) Date received JUL 13 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1944 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to July 9 1944 and that I last saw h— alive on July 9 1944

Immediate cause of death Uremia — Duration 5 weeks

Due to Chronic pyelonephritis — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Wright M. D.
Address 7144. Date signed 7-10-44

G18954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

REGISTERED NUMBER G18954

Every item of information should be carefully supplied; write the causes of death clearly and legibly. Physicians: please write PLAINLY, WITH UNFADING INK. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 Patrick St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Patrick St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Lambert Lambert

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F.

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry Lambert

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 88 Months Days If less than one day hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Samuel Ford

13. Birthplace Baltimore Co. Md

MOTHER 14. Maiden Name Cockerow

15. Birthplace "

16 (a) Informant Henry Lambert

(b) Address 805 Patrick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Thompson

(b) Address 927 N. Mount St.

19 (a) [illegible] (Local registrar) Huntington Williams M.D.

(b) Date received JUL 13 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10/44, 19 .., 22 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/21/44 to 7/10/44, and that I last saw h[illegible] alive on 7/10/44

Immediate cause of death Cerebral Hemorrhage 4 days

Due to Fracture of Hip

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Cecil Ellis M. D.

Address Port Monroe Date signed 7/10/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G18955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83

Registered No. G18955

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St.
(c) Hospital or institution W. B. C. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Rayner Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie M. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: Henry Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1865

8. AGE: Years 78 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Isaac Shiner.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Valentine.
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Western
Location Edmondson Ave

18 (a) Funeral director Edmond P. Donovan
(b) Address 3415-17 Chestnut Ave

JUL 13 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1944 at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1944 to 7/11 1944, and that I last saw ~~him~~ her alive on 7/11 1944.

	Duration
Immediate cause of death: Cerebral Thrombosis	1 day
Due to: Generalized Arteriosclerosis	
Due to:	
Other Conditions: Left hemiplegia	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cerebral Thrombosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.

Address WBCH Date signed 7/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18956 ✓ G18956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 W Hill Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 84 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W Hill St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wheatley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife Robert Wheatley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1882

8. AGE: Years 62 Months 2 Days 10 If less than one day hr. min.

9. Birthplace Worcester Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER 12. Name Daniel Wheatley

13. Birthplace Md

MOTHER 14. Maiden Name Rosella Wright

15. Birthplace Worcester Md

16 (a) Informant Wilmer Conway

(b) Address 109 W Hill Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)

(c) Cemetery or crematory Salisbury

Location Maryland

18 (a) Funeral director Isaac L. Brown & Son

(b) Address 1 Pearl Mont Cemetery Salisbury Md

19 (a) JUL 13 1944 (Date rec'd by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to July 12 1944, and that I last saw her alive on July 11 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to Chronic cardiac Decompensation

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Strauber M. D.

Address 1111 Eutaw Date signed 7/13/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C18957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hopkins Apmts
(c) Hospital or institution: ST Paul & 31 ST

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins Apmts St Paul & 31 ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Wethered Carroll

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. J. Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1880

8. AGE: Years 64 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Harford Co., Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph W. R. Wethered
13. Birthplace Harford Co., Md

MOTHER
14. Maiden Name Lydia Ann Meacham
15. Birthplace Harford Co., Md.

16 (a) Informant Jos. W. Carroll
(b) Address Sparks, Md

17 (a) Burial (b) Date thereof July 14 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emmanuel
Location Glencoe Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 JUL 13 1944 (b) Huntington Williams, M.D.
(Date received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 19 44 to 7/12 19 44 and that I last saw h[illegible] alive on 7/12 19 44

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Mo.
Due to: Arteriosclerosis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. R. Goldsborough M. D.
Address 1923 St Paul St Date signed 7/12/44

G18958
70 #87478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

Registered No. G18958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos, 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2101 Boston St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3 (a) FULL NAME Benjamin Slaughter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1, 1884

8. AGE: Years	Months	Days	If less than one day
60	-1-	-1-	..... hr. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Marion Slaughter
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elsie Slaughter
15. Birthplace Pennsylvania

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart. Location Baltimore, Md.

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 320 Light St.

JUL 13 1944 (Date rec'd by registrar) Hamilton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1944, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17- 1944, to 7-2- 1944 and that I last saw him alive on 7-2- 1944.

Immediate cause of death	Bronchopneumonia	1 wk.
Due to		
Due to		
Other Conditions	Auric. fibrillation, Sarcoma rt. foot.	?

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury.....

23. Signature R. M. Cunningham M. D.

Address Balto City Hosp. Date signed 7-12-44

G18959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 167

G18959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Thomas, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-1178

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace Smithfield Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Barbeluer Fayfield

FATHER 12. Name James Thomas, Sr.
13. Birthplace Smithfield, Virginia

MOTHER 14. Maiden Name Lora Lownes
15. Birthplace Smithfield Va

16 (a) Informant Robert Thomas
(b) Address 1541 S. Madeira St

17 (a) Burial (b) Date thereof July 13-1944
(Burial, cremation, or Removal) (month) (day) (yr.)
(c) Cemetery or crematory Glenwood Cemetery
Location Isleweight Co Va

18 (a) Funeral director Robert E. Wilkins
(b) Address

19 (a) JUL 13 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1944, at 3.10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Real death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to stab wound of chest Homicide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-10-44 at 6:30 P. M.
(b) Where did injury occur? In front of 1629 Jefferson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed during altercation

23. Signature H. L. Wallenmeier M.D.
for Medical Examiner.
Date signed July 11, 1944.

VS 151

G18960
JL - 88843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d Registered No. G18960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. Ellwood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Amrhein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1882

8. AGE: Years	Months	Days	If less than one day
62	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Canton Railroad Co.,

FATHER
12. Name Joseph Amrhein
13. Birthplace ?

MOTHER
14. Maiden Name Regina
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 7/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Filed JUL 13 1944 (b) [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1944, at 9⁰⁵ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1944, to 7/12 1944, and that I last saw him alive on 7/12 1944

Immediate cause of death	Duration
Bronchopneumonia	6 days
Due to Cerebral thrombosis with right hemiplegia	7 days
Due to	
Other Conditions ASCVD HCVD	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Asst

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seymour M.D.
Address BCH Date signed 7/13

C18961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C18961

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 James St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 James St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Breitenbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maude L. Breitenbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1884

8. AGE: Years 60 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business B.& O. R.R.

FATHER
12. Name Rudolph Breitenbach
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Henning
15. Birthplace New Jersey

16 (a) Informant Mrs Maude Breitenbach
(b) Address 1220 James St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Pole
(b) Address 2200 N. Lombard St.

19 JUL 13 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1943 to July 8 1944 and that I last saw alive on 7/8/44 19

Immediate cause of death
Carcinoma of Liver Entertained
Due to Obstruction of Jejunum with Metastasis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1943
Major findings of operation: Carcinoma of Liver
of autopsy: no

Duration 1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chetland Drain M. D.
Address 7 Hall Bldg Date signed 7/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G18962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314 Registered No. G18962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Marylahd
(b) Street address 102 S. Tremont Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Tremont Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNY GULLRICH FREESE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles H. Freese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 30, 1858

8. AGE: Years 86 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George Gullrich
13. Birthplace: unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. Charles H. Freese
(b) Address: 102 S. Tremont Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto. Md.

JUL 13 1944 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 11, 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1944 to July 11 1944, and that I last saw h[illegible] alive on July 10 1944

Immediate cause of death
Coronary Thrombosis
Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
Yrs.
4y

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Hoenes
Address [illegible] Date signed 7/13/44

G18963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

G18963 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes E. Fiddes

3 (b) If veteran, name war —
3 (c) Social Security Account No. No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John J. Fiddes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1877

8. AGE: Years	Months	Days	If less than one day
67	4	20	hr. min.

9. Birthplace England (Town, county and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name John Burlinson
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann O'Connor
15. Birthplace Ireland

16 (a) Informant Mrs. Joseph R. Fiddes
(b) Address 1111 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1944 (Month) (day) (year)
(c) Cemetery or crematory Inner Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 724 E. Eager St.

19 (a) (Date received by Registrar) JUL 13 1944 (b) Registrar's No. [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1944, at 5-30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1944 to July 12th 1944, and that I last saw h. alive on July 12th 44

Immediate cause of death: Cardiac Insufficiency — Duration: 7 days

Due to: Arteriosclerosis — Duration: 7 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel E. Levin M. D.
Address 1761 E. North Ave Date signed 7/13/44.

G18964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18964 Registered No. 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920½ Ethan[illegible] St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920½ Ethan[illegible] St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur T. Jackson
3 (b) If veteran, name war No
3 (c) Social Security Account No.
4. Sex M.
5. Color or race C
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Bertha M. Jackson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1909
8. AGE: Years 35 Months Days If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William E. Jackson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Bertha Frazier
15. Birthplace Balto. Md.

16 (a) Informant Bertha Carter Jackson
(b) Address 1920 ½ Ethan St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Priestman Ln
19 (a) (Date rec'd by registrar) (b) Registrar

JUL 13 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-10- 1944 at 7:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-7- 1944, to 7-13- 1944, and that I last saw h. (M) alive on 7-10- 1944.

	Duration
Immediate cause of death: Respiratory + Cardiac Failure	
Due to: Pulmonary Tuberculosis.	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis E. Hamm M. D.
Address 2340 Madison Ave Date signed 7-13-44

G18965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 h

G18965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN DAVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine A. Davey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1884

8. AGE: Years	Months	Days	If less than one day
59	6	17	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Davey
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Catherine A. Davey
(b) Address 1116 N. Washington Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, '44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans Street

19 (a) JUL 13 1944 (Date received by Registrar) (b) Martin Luther Wallenmeyer M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1944, at 12 Noon M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of the stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M. L. Wallenmeyer M.D. Medical Examiner.
Date signed 7-13-44

G18966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18966 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3433 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Houck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant A. Grace
(b) Address 3433 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14-44 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Frederick Rd

18 (a) Funeral director Joseph Carnaken Sons
(b) Address 612 Washington Blvd

19 (a) (Date received by Registrar) JUL 13 1944 (b) Registrar

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944 at 8 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to July 11 1944 and that I last saw him alive on July 11 1944

Immediate cause of death: Gastric hemorrhage — Duration

Due to: Chronic gastric ulcer

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Large gastric ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.

Address Sinai Hosp Date signed 7/11/44

G18967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G18967~~

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5304 Barbara Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Barbara Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida M. Berry

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife George W.

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 19 1900

8. AGE: Years	Months	Days	If less than one day
44	3	23	..... hr. ..... min.

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER — 12. Name Winfield A. Long
13. Birthplace Md.

MOTHER — 14. Maiden Name Ida E. Eck
15. Birthplace Md.

16 (a) Informant N. George W. Berry
(b) Address 5304 Barbara Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 JUL 13 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1944, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1944 to July 12 1944, and that I last saw h. alive on July 10, 1944.

Immediate cause of death	Duration
Generalized carcinomatosis	3 mo.
Due to Carcinoma of ovary	1yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Grott M. D.
Address 8100 Harford Rd Date signed 7/13/44

Grott 7/13/44

G18968

AB-58076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G18968

Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yr-11mos-6days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.- 21-1884 ?

8. AGE: Years 59 ? | Months 7 ? | Days 20? | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name John Stauh

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Conaway

15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director H. O. Wm. Reese & Son

(b) Address 705 N. Eutaw St.

19 (a) [illegible] (Date received by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11- 1944, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5- 1940 to 7-11- 1944, and that I last saw h er alive on 7-11- 1944

Immediate cause of death Bronchopneumonia — Duration 5 Days

Due to

Due to

Other Conditions Fract. rt. femur — 2 wks.
Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence June 29 1944 at [illegible] M

(c) Where did injury occur? City Hospitals Dr Furman (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No, (Specify type of place)

(e) Means of injury Tripped over a rug and fell.

23. Signature B. M. Cunningham M. D.

Address Balto City Hosp. Date signed 7-12-44

To be Approved by the Medical Examiner

Approved by Hollins F. Jacklin, M D

G18969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V1152

G18969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 — 2nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Fr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 — 2nd St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Joyce Agnes Gauss

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Infant

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1944

8. AGE: Years	Months	Days	If less than one day
—	4	14	hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Clarence H. Gauss
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Edna I Yeager
15. Birthplace Balto Md

16 (a) Informant Parents
(b) Address 3618 — 2nd St. Balto., 25 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto Co. Md

18 (a) Funeral director A. J. Howard Evans
(b) Address 1400 S Charles St Balto 30 Md

19 (a) JUL 13 1944 (Date received by registrar) Huntington Williams (Signature of registrar)

VS 150

MEDICAL CERTIFICATION 5:00

20. DATE OF DEATH July 12, 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944 to July 12 1944 and that I last saw her alive on July 12 1944.

Immediate cause of death	Duration
Atelectasis Congenital	
Due to Atelectasis Congenital	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip W. Kuster, MD
Address 302 Paltimore W Date signed 7/12/44
Keister

G18970 Rubin 203 Patapsco Ave G18970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 Patapsco Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Purcell

3 (b) If veteran, name war —
3 (c) Social Security Account No. 717-07-7236

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Louisa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1880

8. AGE: Years	Months	Days	If less than one day
63	11	1	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Retired - Inspector
11. Industry or business P R R.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Heise
(b) Address 634 Patapsco Ave

17 (a) Burial Transit (b) Date thereof 7/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Washington D. C.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 E Paul St.

19 JUL 13 1944 (a) Huntington Williams, M.D. Registrar
(b) Registrar's signature

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12-44 19 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944 to July 12 1944 and that I last saw him alive on 7-10 1944

Immediate cause of death	Duration
Chronic myocarditis	
Due to myocarditis	
Due to Hypertension Colitis vegetabilis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel Rubin M. D.
Address 203 Patapsco Ave Date signed

G18971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18971 Registered No. 1117a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give County)
(d) Street No. 1618 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles V. Tracy

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 237-09-5928

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Juanita Tracy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1915

8. AGE: Years 29 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace West, Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles L. Tracy
13. Birthplace West Va.

MOTHER
14. Maiden Name Bessie B. Tiggleman
15. Birthplace West Va.

16 (a) Informant Charles L. Tracy
(b) Address 1618 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Grafton W. Va

18 (a) Funeral director Poff & B. M. Walters
(b) Address Pratt & Stricker Sts

(a) JUL 13 1944 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 44 at 7:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gastric Ulcer.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
and Medical Examiner.

Date signed July 13 1944

G18972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G18972

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 S. Carey st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Carey st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Fitzgerald

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7th 1877

8. AGE: Years 67 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Stieff Piano Co.

FATHER
12. Name James Fitzgerald
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Catherine Fitzy
(b) Address 126 S. Carey st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

JUL 14 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th 1944, at 11 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to July 12 1944 and that I last saw him alive on July 12 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to: Hypertension
Due to: Cardio Sarcular Disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Hermann M. D.
Address 1937 Wilkens Date signed 7/13/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. — RESERVED FOR BINDING

VS 180

G18973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 55D

G18973 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/2/44 12-6
(e) Length of stay in Baltimore (yrs., mos., or days) Since 2/2/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Forest Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FELIX WAGNER

3 (b) If veteran, name war: Sp. American
3 (c) Social Security Account No. 36-80-20

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife MOLLIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/1882

8. AGE: Years 61 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name GUSTAVE WAGNER
13. Birthplace GERMANY
14. Maiden Name ANNA METTE
15. Birthplace GERMANY

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17. Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Milton Gorsuch Jr
(b) Address 1217 E. Fort Ave

19 JUL 14 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH July 12, 1944 at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1944 to July 12, 1944, and that I last saw him alive on July 12, 1944.

Immediate cause of death: Carcinoma of the right maxillary sinus, completely destroying right side of face; Terminal aspiration type bronchial pneumonia — Duration: 15 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Calvert Lewis

Address Baltimore, Md. Date signed 7/13/44

VS 150

Va-14281

G18974
AB-88289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G18974
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl-Harris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1944

8. AGE: Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Sadie Alexander
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremation 10AM (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) ~~Cemetery~~ crematory Baltimore City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 JUL 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 1944 at 5.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30- 1944 to 6-18 1944. and that I last saw h. alive on 6-18 1944.

Immediate cause of death	Duration
Bronchio-Pneumonia	1 Day
Due to	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Perry, Jr. M.D. M. D.
Address Balto City Hosp Date signed 7/8/44

G18975

BALTIMORE CITY HEALTH DEPARTMENT

TN. 88555

CERTIFICATE OF DEATH

160a

Registered No. G18975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 10-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 24 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Wilcox St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Baby Girl Jackson (Catherine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1944

8. AGE: Years	Months	Days	If less than one day
		1	24 hr min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Kess
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Jackson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated-3PM (Burial, cremation, or removal) (b) Date thereof 7-7-1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address Huntington Williams, Md.

JUL 14 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th, 1944, at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1944 to 6-17 1944, and that I last saw her alive on 6-17 1944.

Immediate cause of death: Respiratory paralysis — Duration

Due to Cerebral Hemorrhage

Due to Birth Injury

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Kerr Jr. M.D. M. D.
Address Balto City Hosp. Date signed 6/20/44

G18976

BALTIMORE CITY HEALTH DEPARTMENT

TN. 88468 CERTIFICATE OF DEATH 160a

Registered No. G18976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson (Nora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11th, 1944

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Nora Thompson
15. Birthplace W. Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated 10th (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Baltimore City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 JUL 14 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th, 1944, at 10.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11, 1944, to 6-17 1944, and that I last saw h.IM. alive on 6-17 1944.

Immediate cause of death: INTRA CRANIAL Hemorrhage — Duration: 6 days

Due to

Due to

Other Conditions Pneumonia, Ty -28 wks.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H.B. Perry Jr. M.D. M. D.
Address Balto City Hosp Date signed 7/8/44

G18977 ✓ G18977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilbur & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. Lynn St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Oliver Moran

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) June 29 - 1883
8. AGE: Years 61 | Months — | Days 13 | If less than one day — hr. — min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Edward Moran
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Litchfield
15. Birthplace Ireland

16 (a) Informant Mrs Oscar L. Phillips
(b) Address 508 East Lynn St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/ /44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director F. D. Wolfert & Son
(b) Address Baltimore, Md. 515
19 (a) (Date received by registrar) JUL 14 1944 (b) Huntington Williams, M.D.
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12 1944 at 11 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-11 1944, to 7-12 1944 and that I last saw h. alive on 7-12 1944
Immediate cause of death Acute Pulmonary Edema & Cardiac Failure. — Duration Days
Due to Chronic Myocardial Degeneration
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —
23. Signature William J. Bryan M.D.
St. Agnes Hosp
Date signed 7/12/44

G18978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G18978 / 48 B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Lemmum St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Lemmum St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Catherine E. Kelly

3 (b) If veteran, name war ..... 3 (c) Social Security Account No. .....

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward Kelly
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 2nd 1884

8. AGE: Years 59 | Months 10 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER
12. Name John Dower
13. Birthplace Md

MOTHER
14. Maiden Name Lena Steg
15. Birthplace Md

16 (a) Informant Katie Schaefer
(b) Address 410 S. Carrollton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director J. B. Hufnagel Sons
(b) Address 311 Eastern Ave

19 (a) JUL 14 1944 (Date rec'd by registrar) Huntington Hillsman, M.D.

VE 250

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th 1944, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1944, to July 12 1944, and that I last saw h.... alive on July 12 1944.

Immediate cause of death Carcinoma of Uterus

Due to .....

Due to .....

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration
Y.
M.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Edward Carlson, M.D.

Address 2145 W Balto Date signed 7/13/44

G18979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 126 Registered No.

G18979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly. MARG... RESERVED FOR B...DING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Brooms Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Nellie Barnes.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F. 5. Color or race W 6 (a) Single, married, widowed, or divorced. W.
6 (b) Name of husband or wife William Barnes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/23/1868
8. AGE: Years 75 Months 6 Days 20 If less than one day hr. min.
9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business
MOTHER / FATHER
12. Name Mr. Benjamin Monnett
13. Birthplace Md
14. Maiden Name ?
15. Birthplace Md
16 (a) Informant Mrs. Levi Barnes
(b) Address Brooms Island Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Brooms Island
Location Calvert County
18 (a) Funeral director A. A. Hankins & Son
(b) Address Mutual Md
19 (a) Date received JUL 14 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 9:45 M
21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to July 13 1944, and that I last saw h[illegible] alive on July 10 1944.

	Duration
Immediate cause of death Cerebral Embolism	24 hrs
Due to Chronical Pericarditis	3½ da
Due to Ruptured Gall bladder	3½ da
Other Conditions Arterio-sclerotic heart disease (Include pregnancy within 3 months of death)	
Date of operation July 10 1944	
Major findings of operation: Ruptured gall bladder. Chronic pericarditis	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert Zinn Berry M.D.
Address Mercy Hospital Date signed 7/15/44

G18980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 C

G18980 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 E. 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Emma L. Smith

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1876

8. AGE: Years 67 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Standard Oil Co.

FATHER
12. Name Andrew Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emma L. Smith
(b) Address 823 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Harry N. Blight Jr.
(b) Address 4914 Belair Road

JUL 14 1944 (Date rec'd by registrar) Registrar Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1944, at 10.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 9 1944, to June 12 1944, and that I last saw h[illegible] alive on June 12 1944.

Immediate cause of death | Duration

Due to Pulmonary Embolism

Due to Arteriosclerosis 1 yr.

Other Conditions Hypertrophy Heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Frisch M. D.
Address 1823 N. Mount St. Date signed 7/12/44

G18981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G18981

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4118 Eierman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4118 Eierman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Fitzberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Oct. 22. 1867

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
82 83	8	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Martin Fitzberger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Louis Sherman
(b) Address 4118 Eierman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Fifth Reform Road
Location Cardiff & Ponca Sts.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.

JUL 14 1944 (Date received by Registrar) Hamilton for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to July 13 1944, and that I last saw him alive on July 9 1944.

Immediate cause of death: Intestinal Obstruction — Duration

Due to: Malignancy

Due to:

Other Conditions: Senility, Malnutrition (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.
Address 3400 Erdman Ave Date signed 7/14/44

G18982

JL - 46108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G18982 Registered No.

MARG... RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 18-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 10 - 23

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 112 N. Carlton Ave.. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME John Hayes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
48 ?	?	?	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Frank Hayes

13. Birthplace Va.

MOTHER

14. Maiden Name Rebecca

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 13 1944

18 (a) Funeral director Commissioner of Health

(b) Address

JUL 14 1944 Huntington Williams M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 1944, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 6/30 1944 and that I last saw him alive on 6/30 1944.

Immediate cause of death	Duration
Cardiac failure; coronary sclerosis	
Due to ASCVD	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Not Yet

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Ferguson M.D.

Address BCH Date signed 7/4

VS 150

1093

G18983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G18983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 George Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOPHIA WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1874

8. AGE: Years 70 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Richmond Co., Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Spence
13. Birthplace Va.

MOTHER
14. Maiden Name Sophia Taylor
15. Birthplace Va.

16 (a) Informant Mrs. Maud Williams
(b) Address 629 George ~~Williams~~ St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by Local Registrar) JUL 14 1944 Huntington Williams, M.D. 1207 N Costin

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, '44 19 at 5:30 M

21. I certify that death occurred on the date above stated that I attended deceased from July 3 1944 to July 11 1944, and that I last saw ~~him~~ her alive on July 10 1944.

Immediate cause of death Cerebral apoplexy — Duration 8 Days

Due to

Due to

Other Conditions Malignant Hypertension

(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Becton Horn M. D.
Date signed 7/12/44

G18984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G18984
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6517 Baltimore Ave.
(c) Hospital or institution:

26-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6517 Baltimore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B.McClelland

3 (b) If veteran, name war	3 (c) Social Security Account No.
- -	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura E.McClelland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.28.1864

8. AGE: Years	Months	Days	If less than one day
80	3	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John McClelland
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Dickerson
15. Birthplace Md.

16 (a) Informant Mr.Geo.W.McClelland
(b) Address 6517 Baltimore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto.Md.

18 (a) Funeral director Philip Hewig Sons
(b) Address 2024 Orleans St.

19 (a) JUL 14 1944 Registrar
(Date received)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13/44 19 , at 5.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 44 , to July 19 44 and that I last saw h alive on July 13 19 44 .

Immediate cause of death	Duration
Cerebral Hemorrhage	10 hrs.
Due to Arteri Sclerosis Cardio Vascular renal disease	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J W B Davis MD M. D.
Address Baltimore Md (Date signed) 7/14/44

G18985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G18985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Streets
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4939 Denmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GLADYS ELMA HARTLEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-24-1998

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James A. Hartley

6 (c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) May 28, 1895

8. AGE: Years 49 | Months 1 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business Home

FATHER
12. Name Edgar R. Williams
13. Birthplace Balto

MOTHER
14. Maiden Name Sadie Burgee
15. Birthplace Balto.

16 (a) Informant Mrs. Ralph Grove
(b) Address Reisterstown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15-1944 (Month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, Md

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 12 1944 and that I last saw her alive on July 12 1944.

Immediate cause of death Diabetic Coma — Duration ?

Due to Diabetes mellitus

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ____

of autopsy: Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ____

23. Signature Edgar Russell M.D.

Address Women's Hospital Date signed 7-13-44

C18986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92b

C18986 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR LOCAL USING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2230 Etting
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Etting St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Adams (Jennie)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife John Adams
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 1-1876
8. AGE: Years 68 Months 6 Days 10 If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name George Johnson
13. Birthplace Va
MOTHER 14. Maiden name Harriet Sullivan
15. Birthplace Md
16 (a) Informant Mary Keith
(b) Address 2230 Etting St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 7 (day) 16 (year) 44
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. S. Kelso
(b) Address 1303 Pressman St
(c) Date received (month) JUL (day) 14 (year) 1944 (d) Baltimore, Md.

VB 189

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at 6 45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to 1944, and that I last saw h alive on July 11 1944.

	Duration
Immediate cause of death Cerebral Hemmorhage	2 days
Due to Hypertension	
Due to Mitral Insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Fisher M. D.
Address 1612 E. Monument Date signed 7/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

Registered No. G18987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2008 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Rochman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Abraham Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Abraham Rochman
(b) Address 2008 N. Monroe St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Butler St

18 (a) Funeral director Jack Fenis Inc
(b) Address 1429 E. Baltimore St

19 JUL 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14 1944, at 1.10 A. M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy Non-traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Harold Kelly M.D.
Medical Examiner.
Date signed 7/14/44

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G18988 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 W North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Naviasky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Latvia

MOTHER
14. Maiden Name unknown
15. Birthplace Latvia

16 (a) Informant Isaac Naviasky
(b) Address 2020 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pratt Rd + Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1432 E Preston St.

19 (a) JUL 14 1944 Registrar Huntington Mills, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to July 12 1944, and that I last saw h.. alive on July 12 1944

Immediate cause of death Arteriosclerosis Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benjamin Kaplan M. D.
Address 2306 Eutaw Pl Date signed 7-12-44

VS 150

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G18989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G18989

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: 1700 W. Fulton Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 W. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy R. Sayre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James W. Sayre (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1874

8. AGE: Years: 70 | Months: 0 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Marsella Springs, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. James W. Sayre
(b) Address: 1700 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-44 (month) (day) (year)

(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. Tickner & Son
(b) Address: North & Pennsylvania Aves.

19 Date received JUL 14 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1944, at M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Wollaeber M.D.
Medical Examiner.
Date signed July 15, 1944

G18990
VL - 88751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

G18990
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Hampden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Vogh or Maude Vogt

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Gypsy Vogt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1868

8. AGE: Years	Months	Days	If less than one day
76	4	18	hr. min.

9. Birthplace Cockeysville, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name William Childs
13. Birthplace Texas, Md.
MOTHER
14. Maiden Name Mary C.
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 7/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hampden, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 14 1944 Huntington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1944, at 2.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1944, to 7/12 1944, and that I last saw h[illegible] alive on 7/12 1944

Immediate cause of death	Duration
Cerebrovascular Accident	3 days
cerebral hemorrhage	
Due to Generalized arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeon M.D.
Address BCH Date signed 7/13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

MARG[illegible] RESERVED FOR HEADING

G18991 G.P.-82988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 b

Registered No. G18991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mo. 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Barnard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 29, 1923

8. AGE: Years	Months	Days	If less than one day
20	10 9	3 13	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lucian Barnard
13. Birthplace North Carolina

MOTHER
14. Maiden Name Hester Williams
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 15/44 (month) (day) (year)
(c) Cemetery or crematory
Location Hamilton County N. Carolina

18 (a) Funeral director Mrs. R.O. Elliott & Son
(b) Address 1129 N. Caroline St.

JUL 14 1944

(a) (Registrar) (b) Hunter for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1944, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2/43 19 to 7/12/44 19, and that I last saw him alive on 7/12/44 19

Immediate cause of death: Pulmonary Tuberculosis — Duration 1-2 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: as above; TBC peritonitis
of autopsy: Antemortem

PHYSICIAN
Underline the cause to which death should be charged statistically. 11

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Simmons M.D.
Address 13 C H Date signed 7/13

G18992 | BALTIMORE CITY HEALTH DEPARTMENT | G18992

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maryanna (Kuczowski) Wisniewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph Wisniewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64 65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Walenty Zagrajczyk
13. Birthplace Poland

MOTHER
14. Maiden Name Urbanowicz
15. Birthplace Poland

16 (a) Informant Mrs. Joseph Wisniewski
(b) Address 2031 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b) Registrar

JUL 14 1944 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944 to July 13 1944. And that I last saw h[illegible] alive on June 24 1944.

Immediate cause of death: Cardiac hypertrophy
Coronary occlusion — Duration: 1 year
Due to: Arteriosclerosis — Duration: 5 years
Due to: — Duration:
Other Conditions: — Duration:

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature A. F. Rice M. D.
Address 24 S. Mary Date signed July 7/44

G18993

BALTIMORE CITY HEALTH DEPARTMENT ✓ G18993
CERTIFICATE OF DEATH 83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution:
Md. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oden B. Pyle, Sr.
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Ruth P. Pyle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 4, 1872
8. AGE: Years 72 | Months 4 | Days 8 | If less than one day hr. min.
9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Brokerage Sales
11. Industry or business

FATHER
12. Name Ebenezer Ryle
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth M. Abel
15. Birthplace Md.

16 (a) Informant Oden B. Pyle Jr
(b) Address Ambler Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16 '44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave.

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 14 1944 Huntington for Milwaukee, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12/1944, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10/1944 to 7/12/1944 and that I last saw him alive on 7/10/1944

Immediate cause of death Respir. & Circulatory failure at 11:45 PM — Duration

Due to Cerebral hemorrhage occurring at about 10:00 A.M.

Due to Known high B.P. (Most recent readings before 180 & over 120)

Other Conditions & Special defect from "Stroke" 1 yr. ago.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl J. Myers, M.D.
Address Mt. Hem. Hosp. Date signed 7/13/44

G18994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G18994
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 134 S. Louden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey S. Sheppard Corrected by E.T.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 214-20-3449

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married(seperate)

6 (b) Name of husband or wife: Bertha Sheppard Nee Albers
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan. 25 1892

8. AGE: Years 52 | Months 5 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Stove Mounter, Retired
11. Industry or business Sextons

FATHER
12. Name Frank E. Sheppard
13. Birthplace Ohio.

MOTHER
14. Maiden Name Margaret Lehr
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. William Seuss
(b) Address 134 S. Louden Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co. Md.

18 (a) Funeral director Thos. W. Pugliston
(b) Address Glen Burnie Md.

19 (a) JUL 14 1944 (Date rec'd by registrar) Hampton Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 2x 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.
Date signed July 13, 1944

For Dr. H. L. Wollenweber, by Howard J. Maddox, M. D.

G18995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

G18995 Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Sampson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Betty Lynn
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL JUL 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 14 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

1098

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 2:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1944, to July 8 1944, and that I last saw h... alive on July 8 1944.

Immediate cause of death	Erythroblastosis	Duration
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephas, Jr. M. D.
Address Johns Hopkins Hospital Date signed 7-11-44

G18996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 159

G18996 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR LOCAL USE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. 468 Belair Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Spitz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2, 1944

8. AGE: Years	Months	Days	If less than one day
		0	6 hr. 5 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

MOTHER / FATHER
12. Name Joseph Leo Spitz
13. Birthplace Illinois
14. Maiden Name Helen Barbara Arnold
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a)..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHNS HOPKINS MEDICAL SCHOOL JUL 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....
JUL 14 1944 (Signature of local registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1944, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1944, to July 3 1944, and that I last saw h... alive on July 3 1944.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Philip F. Stapleton, Jr. M. D.
Address Johns Hopkins Hospital Date signed 7-7-44

VS 180

1099

G18997 G18997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Guilford Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred E. Kates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: LeRoy R. Kates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1901

8. AGE: Years 43 | Months 5 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at home.

FATHER
12. Name Charles O. White
13. Birthplace Baltimore City

MOTHER
14. Maiden Name Maggie Hoff
15. Birthplace Baltimore County.

16 (a) Informant South Balt. Gen. Hosp. Records
(b) Address 1211 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral.
Location

18 (a) Funeral director C. Vernon Zimmer
(b) Address 4611 Park Heights

19 (a) JUL 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13- 1944 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1944 to 7-13 1944 and that I last saw her alive on 7-13 1944.

Immediate cause of death	Duration
Coronary occlusion.	
Due to hypertension and Diabetes.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin F. Hoff M.D.
Address South Balt. Gen. Hosp. M. D. Date signed 7-13-44

E. B. White Jr.

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

G18998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

✓ G18998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sayles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Milton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Benjamin Williams
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Handforth
15. Birthplace Md

16 (a) Informant Little Sisters of the Poor
(b) Address 1211 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Drummond Ave

19 (a) JUL 14 1944 Washington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1944 to 7/14 1944, and that I last saw h— alive on 19

Immediate cause of death Myocardial insufficiency — Duration One day

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work? No
(e) Means of injury

23. Signature Otto H. Decker M.D.
Address 928 E. North Ave Date signed 7/17/44 M.D.

G18999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered No. G18999

MARK RESERVED FOR RECORDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Knott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Frederick (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name David
13. Birthplace md.

MOTHER
14. Maiden Name Mary Weaver
15. Birthplace md.

16 (a) Informant Little Sisters of the Poor
(b) Address 1211 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Frederick, Md.

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b)

JUL 14 1944

MEDICAL CERTIFICATION 12. P. m.

20. DATE OF DEATH July 13 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944 to 7/13 1944 and that I last saw h. alive on 19

Immediate cause of death Uremia — Duration 1 day

Due to Chr Nephritis

Due to Chr Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work?
(e) Means of injury

23. Signature Otto H. Beuker M.D.
Address 928 E. North Ave Date signed 7/14/44

G19000 Fiori ✓G19000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 S. Central Ave
(e) Citizen of foreign country? Central (Yes or No) (If non-native, give country)
If yes, name country

3 (a) FULL NAME Anna Fiori

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Dominick Fiori
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) February 24, 1895

8. AGE: Years	Months	Days	If less than one day
49	5	18	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Meigarelli
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Galetti
15. Birthplace Italy

16 (a) Informant Dominick Fiori
(b) Address 209 S. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Kendall Chapel
(b) Address 312 S. Hanover St

19 (a) JUL 14 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1944, at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1944, to 7/12 1944, and that I last saw her alive on 7/12 1944.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	
Due to (b) Pulmonary Edema, Hypostatic Congestion	
Due to (c) Chronic Glomerulonephritis	
Other Conditions: Bronchopneumonia, Coronary sclerosis ??	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Musella, M.D.
Address Sinai Hosp. Date signed 7/12/44

PLEASE WRITE PLAINLY; cause or age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Leonard Musella

G19001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19001 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Old Orchard Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Old Orchard Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Frank Forrester
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Grace Lippencatt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 25. 1871
8. AGE: Years 73 Months 5 Days 18 If less than one day hr. min.
9. Birthplace Balto. Md. (town, county and state)
10. Usual Occupation Clothing Salesman
11. Industry or business Hardy Meyers, Inc.

MOTHER / FATHER
12. Name Tom. E. Forrester
13. Birthplace Md.
14. Maiden Name Laura M. Marrow
15. Birthplace Md.

16 (a) Informant James E. Forrester
(b) Address 5119 Greenwich Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd
18 (a) Funeral director Harry H. Nitter
(b) Address 410 Edmondson Ave
JUL 14 1944 (b) Huntington Md. Registrar
(Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13/44. 19 at 2:30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1944 to 7-13 1944 and that I last saw h[illegible] alive on 7-12 1944

Immediate cause of death Arteriosclerotic heart disease — Duration yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. Edward Leach M. D.
Address 14 E. Eager St Date signed 7-14-44

G19002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19002 Registered No. 1192

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Bruce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Malus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/2/44

8. AGE: Years	Months	Days	If less than one day
	3	12	hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard P. Matus
13. Birthplace Balto.

MOTHER
14. Maiden Name Betty J. Scott
15. Birthplace Pa.

16 (a) Informant Howard P. Matus
(b) Address 329 S. Bruce

17 (a) Burial (b) Date thereof July 17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Harry H. Fritzke
(b) Address 1401 Edmonds Ave

19 (a) (b) Registrar
(Date rec'd by reg.)

JUL 14 1944 Huntington-Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14-44 19 at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1944 to 7/14 1944, and that I last saw h. alive on 7/14 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Baby diarrhea	
Due to Infections Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ad Buzzafo M. D.
Address St Agnes Hosp Date signed 7-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19003
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 ASHLAND AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst: (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA M. SCHMITT

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife JOHN M. SCHMITT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 30 1893

8. AGE: Years 51 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name JOHN ROSE
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name EMMA S. GRAY
15. Birthplace BALTO. MD.

16 (a) Informant MARIE SCHMITT (DAUGHTER)
(b) Address 2803 ASHLAND AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 15/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 JUL 14 1944 (Date received by registrar) Huntington Williams, MD

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 12 1944 at 12/15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to July 12 1944, and that I last saw h[illegible] alive on July 12 1944.

Immediate cause of death: Coronary Thrombosis
Hypertension

Due to

Due to

Other Conditions Heart Failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 mos. 2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith

Address 1223 E. Monk. Date signed 7/14/44

Balto-2,

G19004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G19004

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2113 SINCLAIR LANE (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mark C. Bradley

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 27 1897

8. AGE: Years	Months	Days	If less than one day
46	6	17	hr. min.

9. Birthplace BALTIMORE MD? (Town, county, and state)

10. Usual Occupation MACHINEST

11. Industry or business BETH. STEEL CO.

FATHER

12. Name MARK BRADLEY

13. Birthplace BALTO.

MOTHER

14. Maiden Name JOHANNA VOGEL

15. Birthplace GERMANY

16 (a) Informant GERTRUDE BREITENBACH (SISTER)

(b) Address 7048 BELCLARE ROAD DUNDALK

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 17/44 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

JUL 24 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 1:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1944, to July 14 1944, and that I last saw him alive on July 14 1944.

Immediate cause of death	Duration
Carcinoma of colon at sigmoid flexure & intestinal obstruction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 8, 1944

Major findings of operations: Same as above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul H. Lukats M.D.

Address 1213 Light St. Date signed July 17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

G19005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

G19005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. LeKwood Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. LeKwood Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS S. ALLEN.
3 (b) If veteran, name war
3 (c) Social Security Account No. 717-07-7733

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elizabeth Rothenberger
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 23rd 1884

8. AGE: Years	Months	Days	If less than one day
60	4	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Penna. R.R. Co.

FATHER
12. Name Henry Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie Pfaff
15. Birthplace Md.

16 (a) Informant Thelma Allen
(b) Address 405 N. LeKwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director E. J. Fannon & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) JUL 14 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to July 12 1944, and that I last saw h[illegible] alive on July 12 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Fibrosarcoma hip	
Due to	
Other Conditions Generalized Metastases	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shorofsky M.D.
Address 601 N. Mulberry St Date signed 7/13/44

G19006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G19006 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore Co.
(a) State Md. (b) County Della
(c) City or town Rural - Della, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Della (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maud Harden

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1896

8. AGE: Years 47 | Months 8 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Deaflinger

13. Birthplace Del.

MOTHER 14. Maiden Name Cora L. Rittenauer

15. Birthplace Del.

16 (a) Informant Mrs. Joseph E. Harden

(b) Address Della, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)

(c) Cemetery or crematory St. Johns, Location Ellicott City, Md.

18 (a) Funeral director Easton Road, Ellicott City, Md.

(b) Address

19 (a) (Registrar) (b) Huntington Mills, Md.

JUL 15 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944 at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 ... to 19 ... and that I last saw h... alive on 19 ...

Immediate cause of death

Cirrhosis of liver

Due to ascites

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Bryant M. D.

Address St. Agnes Hosp. Date signed 7-17-44

G19007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

G19007
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 W Cross St
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) all
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 W Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Wm B Davis Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 - 1854

8. AGE: Years 89 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name James McCall
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Collins
15. Birthplace Baltimore Md

16 (a) Informant William B Davis Jr
(b) Address 933 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)

(c) Cemetery or crematory Western
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) (Date received by registrar) JUL 15 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1944 to July 13 1944
and that I last saw her alive on July 13 1944.

Immediate cause of death Auricular Fibrillation
Hypertension

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 months, 3 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Hom Hates
23. Signature Address 517 Dodd St Date signed 7/13/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G19008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 452 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 452 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Bussman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Karl Bussman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23rd 1865

8. AGE: Years 79 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name ? Shower
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Margaret Fout
(b) Address 452 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JUL 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944; at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to July 12 1944; and that I last saw him alive on July 12 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hr.
Due to	
Due to Cortical Sclerosis	2 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M. D.
Address 1732 N. Monroe Date signed July 13 1944

G19009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G19009 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md
(c) Hospital or institution: South Balt. Gen. Hosp 7-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 McElderry Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Moses

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Brunswick
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Maryland Dry Dock

FATHER 12. Name Deceased, Name Not Known
13. Birthplace Georgia

MOTHER 14. Maiden Name Sallie Jones
15. Birthplace Georgia

16 (a) Informant Lula Adams
(b) Address 909 N. Wolfe St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 7/17/44
(c) Cemetery or crematory Mt. Calvary
Location A.A. County

18 (a) Funeral director Lottie Hoge
(b) Address 1408 Eastland Ave

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

JUL 15 1944

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 8 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-13-44 at 6:35A M. 25/6
(b) Where did injury occur? Bethlehem Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? outside Auto race track While at work? No.
(d) Means of injury truck & trailer

23. Signature J. J. Wallenmeier M.D.
Medical Examiner.
Date signed July 13, 1944.

G19010 ~~[illegible]~~ BEHANNA

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 108

Registered No. G19010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto Md.
(c) Hospital or institution: St Josephs. 9-9
(d) Length of stay in Hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Manassas (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Chestnut. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

3 (a) FULL NAME Noah Behanna

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Sept 7-1914

8. AGE: Years 29. Months 10 Days 7 If less than one day hr. min.

9. Birthplace Donora Penn. (Town, county, and state)

10. Usual Occupation
11. Industry or business Tin Smith Worker.

FATHER 12. Name Noah Behanna.
FATHER 13. Birthplace Donora Penn.

MOTHER 14. Maiden Name Lena Smith.
MOTHER 15. Birthplace Monessen Penn.

16 (a) Informant Elmer Bates.
(b) Address 715 N. Old Town St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-44 (month) (day) (year)
(c) Cemetery or crematory Belle Vernon
Location Belle Vernon Pa.

18 (a) Funeral director Charles H Kaufmann
(b) Address 637 Washington Blvd

19 JUL 15 1944 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1944 to 7-14 1944.
and that I last saw h[illegible] alive on 7-14 1944.

Immediate cause of death Cardiac failure

Due to Rheumatic heart disease (valvular)

Due to

Other Conditions Lobar pneumonia Rt Middle lobe (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

(e) Signature Thomas B Bauman M. D.
Address St Joseph Hospital Date signed 7-14-44

G19011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19011
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Parkside Dr.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 1
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 505 S. Patterson Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustav A. Meurer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Susie Meurer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 17. 1863

8. AGE: Years 80 | Months 9 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town or county, and state)

10. Usual Occupation Retired
11. Industry or business Letter Carrier

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Louis Gilbert
(b) Address 3800 Parkside Drive

17 (a) Burial (b) Date thereof July 15. 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Ogsmed St

18 (a) Funeral director J. Fleemans & Son
(b) Address 32 S. Broadway

19 (a) (Date rec'd by registrar) (b) Registrar
JUL 15 1944 Washington Matthews, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13. 1944 at 2.45 P.M.

21. I certify that deceased died on the date above stated; that I attended deceased from July 9 1944 to July 13 1944. and that I last saw h[illegible] alive on July 12 1944

Immediate cause of death Cardiac Depression — Duration 4 days
Due to Cardiac Depression
Due to —
Other Conditions Hypertension C.V.D. Arteriosclerosis, generalized
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Edward A. Dyer, Jr. M. D.
Address University Hosp Date signed 7/15/44

G19012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G19012
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & Slat St.
(c) Hospital or institution: U. S. Marine Hospital
Since Mar. 10, 1944
(d) Length of stay in hospital or inst. (yrs., mos., or days)
Since Mar. 10, 1944
(e) Length of stay in Baltimore (yrs., mos., or days)

12 - 1

2. USUAL RESIDENCE OF DECEASED:
(a) State: Pa. (b) County:
Street: 1401 Highland Avenue
(If outside city or town limits, write RURAL and give town)
City: New Castle
(If rural give location)
(c) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) FULL NAME CHARLES KNESAL COOPERRIDER

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Effie Hazen Hedges
(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1889

8. AGE: Years	Months	Days	If less than one day
55	1	11	hr. min.

9. Birthplace: Newark, Ohio (Town, county, state)
10. Usual Occupation: In charge Investigations
11. Industry or business: U.S.Forest Service Emergency Rubber Project

FATHER
12. Name: Joel Cooperrider
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Emma Knesal
15. Birthplace: Ohio

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 15, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: Elizabeth Funk Orr
(b) Address: 115 E. Fayette St.

19 (a) JUL 15 1944 (Date received by registrar) Permit issued from Md. Address, Md.

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH July 15, 1944, at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10, 1944 to July 13, 1944. and that I last saw h. im alive on July 13, 1944.

Immediate cause of death: Subacute bacterial endocarditis. Numerous embolic phenomenae, petechiae in the skin and mucus membranes, infarcts in the brain, spleen and kidneys.

Duration
Since Oct. 1943

Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. Acheson M. D.
Address: Baltimore, Md. Date signed: 7/14/44

ECC-51589

19013 QUEEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19013 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 693 Pierce
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 693 Pierce (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Queen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife William Queen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29 1878

8. AGE: Years 65 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Lancaster, Pa. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Samuel King
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden Name Louise Hunter
15. Birthplace Canada

16 (a) Informant Mamie M. Allen Duck
(b) Address 693 Pierce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St

JUL 15 1944 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944 at 6:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to July 12 1944 and that I last saw h[illegible] alive on July 12 1944

Immediate cause of death: Coronary Occlusion — Duration
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 730 N Eutaw St Date signed July 15 1944

G19014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157D

Registered No. G19014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore [illegible] Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl ~~Mendes~~ Menalis Menalis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/21/44

8. AGE: Years	Months	Days	If less than one day
		18	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business —

FATHER
12. Name Francis T. Menalis
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Ruth ~~Dufresne~~
15. Birthplace Bowie, Md.

16 (a) Informant Ruth Menalis
(b) Address 1403 W. Fayette St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 15 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1944 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1944 to 7/9 1944.
and that I last saw h[illegible] M alive on 7/9 1944

Immediate cause of death	Duration
* Respiratory Cardiac failure	1 day
Due to Dehydration, acidosis	5 days
Due to Congenital defects of malformation of adrenal hemorrhage	18 days
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Alfred T. Williams M. D.
Address University Hospital Date signed 7/10/44

VS 150

2001

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19015 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 N. Duncan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 954 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Garritzen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Peter J. Garritzen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1854

8. AGE: Years	Months	Days	If less than one day
90	4		hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation housework
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Wm F. Garritzen
(b) Address 954 N. Duncan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUL 15 1944 Registrar Williamson MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 10:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1944 to July 12 1944, and that I last saw h alive on July 12 1944

	Duration
Immediate cause of death Uremic Hypocalcitis	2 days
Due to	
Due to Acute Cardiac Dilatation	1 day
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 600 N Patterson Pk Date signed 7-17-44

G19016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1124a

Registered No. G19016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 1926 Penn ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Penn ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Chesley
3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife No
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 23 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name John H Chesley
13. Birthplace Md

MOTHER 14. Maiden Name Mary Green
15. Birthplace Md

16 (a) Informant John H Chesley
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/44 (month) (day) (year)
(c) Cemetery or crematory Aquasco, Md
Location Md

18 (a) Funeral director Geo. B. Kelsey
(b) Address 1303 Pressman St

19 (a) Date received July 15 1944 (b) Thos. Taylor Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11 1944 to 7-13-1944 and that I last saw h-- alive on 7-13-1944.

Immediate cause of death Cardiac Dilatation, Acute Gastro-Enteritis, Cirrhosis of Liver, Duration

Due to Alcoholism, Chronic Constipation,

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature Wm R Boarman MD
Address 135 Fulton St Date signed 7/16/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19017

G19017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3204 Barclay st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Barclay st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roly Conway.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-20-1887

8. AGE: Years 57. | Months 13 | Days 23. | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name Caroline ?

15. Birthplace Va

16 (a) Informant Clarence Conway

(b) Address 3204 Barclay st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 16 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location A - E County Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania

JUL 15 1944
(Date rec'd by registrar)

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1942, to July 13 1944; and that I last saw deceased alive on July 10 1944

Immediate cause of death Hypertension Cardio Renal Failure — Duration ?

Due to

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Adams M. D.

Address 3126 W Date signed July 14 1944

G19018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G19018 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 S. Montford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 S. Montford Avenue (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME: Andrew Joseph Sliwa

3 (b) If veteran, name war: ———
3 (c) Social Security Account No. 215-01-0751

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophia
6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): October 26, 1888

8. AGE: Years: 55 | Months: 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Ropczyce, Poland (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business:

FATHER
12. Name: John Sliwa
13. Birthplace: Ropczyce, Poland

MOTHER
14. Maiden Name: Mary Kolowiczak
15. Birthplace: Ropczyce, Poland

16 (a) Informant: Mrs. Sophia Sliwa
(b) Address: 833 S. Montford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road

18 (a) Funeral director: M. J. Orlowski & Sons
(b) Address: 1805 Eastern Ave

JUL 15 1944 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to July 13 1944, and that I last saw h[illegible] alive on July 13 1944.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 7/13/44
Due to: Carcinoma of Lung — 3/1/44
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Williams Krypaner M. D.
Address: 801 N. Kenwood Ave Date signed: 7/13/44

G19019

G19019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 S. Regester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. Regester Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ZUBROWSKI

3 (b) If veteran, name war ———
3 (c) Social Security Account No. 218-18-2698

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) July 16, 1885

8. AGE: Years	Months	Days	If less than one day
58	11	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Joseph Zubrowski
13. Birthplace Poland

MOTHER
14. Maiden Name Jadwiga Zamenska
15. Birthplace Poland

16 (a) Informant Mrs. Lillian Zubrowski
(b) Address 519 S. Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski Sons
(b) Address 1808 Eastern Ave

19 JUL 15 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944, to July 13 1944, and that I last saw ... alive on July 13, 1944.

Immediate cause of death	Duration
acute nephritis	1 mo.
Due to acute orchitis	1 week
Due to	
Other Conditions ———	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: ———
of autopsy: ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— While at work? ———
(Specify type of place)
(e) Means of injury ———
23. Signature John J. Frazer M. D.
Address 2617 Eastern Ave. Date signed 7/14/44

G19020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G19020

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. Collington Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Collington Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HEDWIG FIGINSKI

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. 212-02-7427

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1891

8. AGE: Years 53 | Months 2 3 | Days 29 | If less than one day hr. min.

9. Birthplace Torun, Poland
(Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business

FATHER
12. Name Anthony Figinski
13. Birthplace Poland

MOTHER
14. Maiden Name Martha Nowicka
15. Birthplace Poland

16 (a) Informant Mrs. Martha Figinska
(b) Address 410 S. Collington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski Home
(b) Address 1808 Eastern Ave.

19 JUL 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 3.50a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1944, to July 14 1944, and that I last saw h[illegible] alive on July 13 1944

	Duration
Immediate cause of death: Acute Pulmonary Oedema	1 day
Due to: Pyelo-Nephritis	1 month
Due to: Hypertension & Cardiac Hypertrophy	14 yrs
Other Conditions: Marked Oedema, Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature H. F. Rees M. D.
Address 24 S. Broadway Date signed July 15/44

G19021

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93D

G19021

Reg. Dist. No. .....

1. PLACE OF DEATH:

County .....

City or town Baltimore Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 1609 Dundalk Ave. 26

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1609 Dundalk Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME SARAH C. SPRATT

3. (b) Social Security Number V

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Samuel S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 17, 1854

8. AGE: Years	Months	Days	If less than one day
89	9	27	..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business .....

FATHER 12. Name John Coulter

13. Birthplace Ireland

MOTHER 14. Maiden name Unknown

15. Birthplace do

16. Informant Mrs. Henry W. Peters

Address 1609 Dundalk Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/16/44 (month) (day) (year)

Cemetery or crematory .....

Location Pittsburgh, Pa.

18. Funeral director William J. Tickner & Sons

Address North & Penna. Aves.

19. JUL 15 1944 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 44 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 11 19 44 to July 14 19 44 and that I last saw h.. alive on July 14 19 44

Immediate cause of death Senile arteriosclerosis DURATION

Chronic myocardio degeneration

Terminal Bronchial Pneumonia

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Eugene F Nevin MD M. D. or other

Address 700 Morning Sun Rd. Date signed 7-15-44

G19022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Andrew Stanley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William Stanley 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10-77

8. AGE: Years 67 | Months 34 | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Jerry Andrews
13. Birthplace Va

MOTHER 14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Catherine L. Stanley
(b) Address 1602 Druid Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Sam'l R. Chase Son
(b) Address 638 N. Eutaw St

19 (a) JUL 15 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944, at 5 P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1 1944 to July 11 1944, and that I last saw h alive on July 11 1944

Immediate cause of death Cardiac Vascular Renal

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas. L. Hall
Address 8 E. Pleasant Date signed 7/16/44

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19023

ASHe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

× ✓ G19023 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? N.A. (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Mitchell Ashe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Mrs. Emma Ashe

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) SEPT [illegible] 1862

8. AGE: Years 81 | Months 10 | Days — | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Mr. Harry Ashe
13. Birthplace England

MOTHER
14. Maiden Name Mary A. ?
15. Birthplace Maryland

16 (a) Informant Harry Ashe
(b) Address Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore

18 (a) Funeral director Edw A Tipton
(b) Address 24 Penniptead Md

19 JUL 15 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944 to July 15 1944, and that I last saw him alive on July 14 1944.

Immediate cause of death: Cardio Respiratory Failure — Duration:

Due to: Hypertensive Cardio Vascular Disease

Due to:

Other Conditions: ? Malignancy Lower G.I. Tract

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Loffth M. D.

Address Union Memorial Hosp Date signed 7/15/44

G19024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G19024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1626 Clarkson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-3

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1626 Clarkson St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE A. HERCHENHAHN (HERCHENHAN)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife: William C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1876

8. AGE: Years	Months	Days	If less than one day
68	I	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name John T. McGee

13. Birthplace Ireland

MOTHER

14. Maiden Name Bridget E. ?

15. Birthplace Ireland

16 (a) Informant Family

(b) Address 1626 Clarkson St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway

18 (a) Funeral director Jas. A. McCusker

(b) Address 130 E. Fort Ave.

19 JUL 15 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5-44 19 , to 7-12-44 19 , and that I last saw her alive on 7-12-44 19 .

Immediate cause of death Myocardial failure

Due to Coronary Arteriosclerosis Chronic Myocarditis

Due to Hypertensive cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Raymond Otto Pangle M. D.

Address 2102 Bobb Ave. Date signed 7-13-44

Raymond Pangle

G19025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G19025 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA BLASE

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1882

8. AGE: Years	Months	Days	If less than one day
61	8	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business B. & O. R. R.

FATHER
12. Name Otto Blase
13. Birthplace Germany

MOTHER
14. Maiden Name Adeline Benois
15. Birthplace Chili

16 (a) Informant Mrs. Anita B. King
(b) Address Savage, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 16 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to Suicide

Other Conditions Chronic mental depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-14-44 M.
(b) Where did injury occur? Home address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Butcher knife

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed 7-15-44

G19026 ✓ G19026

G19026 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 13/a

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MOLLIE B. Shultz

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1872

8. AGE: Years	Months	Days	If less than one day
72	2	13	hr. min.

9. Birthplace Hanover, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John D. Slagle
13. Birthplace Pa.

MOTHER
14. Maiden Name Susan E. Beard
15. Birthplace Pa.

16 (a) Informant Miss Helen A. Shultz
(b) Address 2705 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) (b) (Signature and title)

JUL 16 1944 (Filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15 1944, at 3.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1944, to 7-15 1944, and that I last saw h alive on 7-15 1944.

Immediate cause of death Cardio renal-disease. — Duration 1 yea.
Due to Arteriosclerosis —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas H. Warren M. D.
Address 2604 Garrison Blvd. Date signed 7-15-44

G19027 ✓ G19027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Park Ave. & Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EFFIE MESSICK

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1871

8. AGE: Years	Months	Days	If less than one day
72	8	6	hr. min.

9. Birthplace Quantico, Md. (Town, county, and state)

10. Usual Occupation Fitter

11. Industry or business Singer Sewing Machine Co.

FATHER
12. Name Columbus Messick
13. Birthplace Wicomico Co.

MOTHER
14. Maiden Name Marietta Venables
15. Birthplace Wicomico Co.

16 (a) Informant Mr. John E. Magers, Executor
(b) Address Fidelity Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/44 (month) (day) (year)

(c) Cemetery or crematory
Location Quantico, Wicomico Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 16 1944 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1944 to 7/14 1944, and that I last saw her alive on 7/13 1944

Immediate cause of death	Duration
Myocarditis	
Due to Carcinoma of Uterus & Ovary	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation 5/23/44

Major findings of operation: Adeno-Carcinoma Ovary & uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Kinnier Ford

Address 20 E. Preston St Date signed 7/15/44

G19028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X V 127a

Registered No. G19028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hunkelberg, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vinton P. Caple

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife C. Caple

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace near Westminster (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norris Caple
13. Birthplace Westminster

MOTHER
14. Maiden Name Ella Gorsuch
15. Birthplace Westminster

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 18 1944 (month) (day) (year)
(c) Cemetery or crematory Sandy Mount
Location Near Westminster

18 (a) Funeral director J. Frances Reese
(b) Address Westminster

19 (a) (Date received by State Registrar) Huntington Miller M.D. Registrar

JUL 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to July 15 1944 and that I last saw h[illegible] alive on July 15 1944

Immediate cause of death Leukemia
Heart failure

Due to Cyst of Ovaries & appendicitis appendectomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 8th - 1944

Major findings of operation: chronic appendicitis -

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Gutheman M. D.

Address University Hosp Date signed 7/15/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G19029 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/9/1944
(e) Length of stay in Baltimore (yrs., mos., or days) 18 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town Escanaba
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 South 12th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS BROWN

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/19/1890
8. AGE: Years 53 | Months 11 | Days 25 | If less than one day hr. min.
9. Birthplace Escanaba, Michigan (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Michael Brown
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-44 (month) (day) (year)
(c) Cemetery or crematory Location Escanaba Mich
18 (a) Funeral director Pat Bee Odey
(b) Address 4644 York Rd. Huntington Woods, Mich.

JUL 16 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH July 14, 1944, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1944, to July 14, 1944, and that I last saw him alive on July 14, 1944.

Immediate cause of death 1. Severe toxic hepatitis with marked fatty metamorphasis and atrophy. Duration: Unk.
Due to 2. Moderate toxic myocarditis, splenitis and nephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Aebrecw M. D.
Address Baltimore, Md. Date signed 7/14/44

Va-14516

G19030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G19030

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 883 W Fayette St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Cora A Stanley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 20 1874

8. AGE: Years	Months	Days	If less than one day
70	2	24	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name John Stanley
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Mrs Frank Stanley
(b) Address 883 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)

(c) Cemetery or crematory Methodist Cem.
Location Shenandoah, Va.

18 (a) Funeral director John Howard Lyon
(b) Address 901 03 Hollins St

19 (a) JUL 15 1944 (Date rec'd by registrar) Clinton Robinson M.D.

VE 2

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 4:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to July 14 1944, and that I last saw h alive on 19

Immediate cause of death Cerebral Hemmorrhage — Duration 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Stanley Jr

Address 901 Shenandoah Date signed 7/15/44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19031 Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2645 Francis St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Francis St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Holland.

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 191-03-0846

4. Sex: M.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Martha M Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 - 1892

8. AGE: Years 51 | Months 8 | Days 11 | If less than one day: hr. min.

9. Birthplace Bethelboro Pa. (Town, county, and State)

10. Usual Occupation Stationary Engineer
11. Industry or business Engineer

FATHER
12. Name Frank M. Holland
13. Birthplace Uniontown Penna.

MOTHER
14. Maiden Name Alice Johnson
15. Birthplace Penna.

16 (a) Informant Mr. Martha Holland
(b) Address 2645 Francis St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 15, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Dunbar, Pennsylvania

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) Date received by registrar JUL 16 1944 (b) Registrar Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1944 to July 15 1944, and that I last saw h alive on July 15 1944

Immediate cause of death
Chr. Myocarditis
Due to Chr. Interstitial
Due to nephritis

Duration: Yrs. 1942 / mos. 1942

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Brown M. D.
Address 1663 W. North Ave. Date signed 7/15/44

G19032 Mitnick ✓ G19032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Fendall ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sam B Mitnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Barbara.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1900

8. AGE: Years	Months	Days	If less than one day
44	6	5	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name Jacob J. H. Mitnick
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie R. Schuchs
15. Birthplace England

16 (a) Informant Louis Mitnick
(b) Address 3431 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St

18 (a) Funeral director Sol Leoman's Bro
(b) Address 1124-26 W North ave

JUL 16 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1944, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944 to 7/13 1944, and that I last saw h— alive on 7/13 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M. D.
Address WB & L Date signed 7/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G19033 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1211 Wilcox St

(c) Hospital or institution: at Home 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1211 Wilcox St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary H. Baker

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: David Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4 1858

8. AGE: Years	Months	Days	If less than one day
86	4	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at Home

FATHER

12. Name John F. Sunbrink

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Christina Depkin

15. Birthplace Germany

16 (a) Informant Mrs Ruth (Daughter)

(b) Address 1211 Wilcox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cemetery

Location 5712 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son

(b) Address 924 E. Eager St.

JUL 16 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1944 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to July 14 1944 and that I last saw him alive on July 7 1944.

Immediate cause of death	Duration
Arteriosclerosis Heart disease	
Due to Senility and arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Conrad L. Rutty M. D.

Address 7237 Lake Ave Date signed 7/15/44

G19034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19034 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Ave. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Simels

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Israel Simels
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Meyerowitz
15. Birthplace Russia

16 (a) Informant Pauline Simels
(b) Address 2518 Ave. W. Brooklyn NY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-44 (month) (day) (year)

(c) Cemetery or crematory New York, N. Y.
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 39 Huntington Ave Boston Mass

JUL 16 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15- 1944, at 2-30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Muldeis M.D. Medical Examiner.
Date signed 7-16-44

G19035

BALTIMORE CITY HEALTH DEPARTMENT ✓ G19035

CERTIFICATE OF DEATH 55E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Forest Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Meyers, Mrs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Abraham Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Former wife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name Russia
15. Birthplace

16 (a) Informant Mrs. Meyer (Son)
(b) Address 3511 Forest Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-44 (month) (day) (year)
(c) Cemetery or crematory Adath Israel Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Baltimore St

19 JUL 16 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944, to 7/14 1944, and that I last saw her alive on 7/14 1944.

Immediate cause of death Cancer Rupture from ruptured — Duration

Due to ?

Due to ?

Other Conditions Generalized Carcinoma (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma

of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Peterkin M. D.
Address Sinai Hospital Date signed 7/19/44

G19036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19036
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 E. Balto St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Overback

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Morris -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Louis Polski
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie -
15. Birthplace Russia

16 (a) Informant Morris Overback
(b) Address 2227 E. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St.

JUL 16 1944
(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/44 1944, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13/ 1944, to 7/14 1944, and that I last saw her alive on 7/14 1944.

Immediate cause of death Myocardial insufficiency — Duration

Due to Hypertensive cardio-vascular dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Myocardial insuffic. dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Akman M. D.
Address Sinai Hospital Date signed 7/14/44

G19037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51C

Registered No. G19037

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk Drive & 31st West

(c) Hospital or institution: US Marine Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2915 Parkwood Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Albert Danoff

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gertrude Kitt

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 11/20/15

8. AGE: Years 28 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Soldier.

11. Industry or business

FATHER — 12. Name Solomon Danoff

13. Birthplace Russia.

MOTHER — 14. Maiden Name Sarah Rose

15. Birthplace Russia.

16 (a) Informant Clinical Record Hosp.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-44 (month) (day) (year)

(c) Cemetery or crematory Pinedale

Location

18 (a) Funeral director Jacob Freiwirth

(b) Address 1439 E. Balto St

JUL 16 1944 (Date received by Registrar)

(b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1944, to 7/15 1944, and that I last saw him alive on 7/15 1944.

Immediate cause of death: Embryonal Carcinoma Testicle — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/31/44

Major findings of operation: Embryonal Carcinoma of right testicle

of autopsy: [illegible]

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward L Adams Pa Surg M. D.

Address U.S. Marine Hosp Balt. Md. Date signed 7/15/44

375827 G19038 STAYER BALTIMORE CITY HEALTH DEPARTMENT ✓ G19038

CERTIFICATE OF DEATH 108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Linwood Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Joseph Stayer

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Theresa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-90

8. AGE: Years	Months	Days	If less than one day
54	4	3	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business

FATHER — 12. Name Michael Stayer
13. Birthplace Hungary

MOTHER — 14. Maiden Name Anna
15. Birthplace Hungary

16 (a) Informant Rezonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (b) Registrar

JUL 16 1944 Baltimore, Md.

VS 150

MEDICAL CERTIFICATION 12 15

20. DATE OF DEATH July 13 1944 P., M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1944 to 7-13 1944 and that I last saw him alive on 7-13 1944

Immediate cause of death Renal insufficiency
? due to hepato renal syndrome
Due to ? sulfamerazine intoxication
Other Conditions Acute necrosis of liver
Lobar pneumonia, R.U.L.
(Include pregnancy within 3 months of death)
Date of operation chronic duodenal ulcer
Major findings of operation:
of autopsy: not reported yet

Duration
19 days

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John R. Birmingham
Address J.H.H. Date signed 7/14/13

G19039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1725 Darley Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days): None

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: City

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1725 Darley Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3 (a) FULL NAME: John P. Quinn

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 219-01-1049

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary B. Smelzer

6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): March 8th, 1883

8. AGE: Years: 61 Months: 4 Days: 5 If less than one day: ##### min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Burne Bottling Machine Works Inc.

FATHER

12. Name: Martin F. Quinn

13. Birthplace: Ireland

MOTHER

14. Maiden Name: Jane A. Young

15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary B. Quinn (Wife)

(b) Address: 1725 Darley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 17, 1944 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Belair Rd. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.

(b) Address: 1735 Harford Avenue

19 (a) (Date received by registrar) (b) Registrar

JUL 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to July 13 1944, and that I last saw him alive on July 13 1944.

Immediate cause of death: Coronary Thrombosis — Duration: Actual hours

Due to:

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Samuel L. Quinn

Address: 1761 E. North Ave. Date signed: 7/14/44

Samuel L. Quinn

G19040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19040 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Highwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 714 Highwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wills

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William F
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3 1885

8. AGE: Years 55 5 M. Months 7 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Brady.
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lillian E. Kenny
(b) Address 714 Highwood Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 4217 Eastern Ave Baltimore, Md.

JUL 16 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944 at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Asst. Medical Examiner.
Date signed 7-15-44

VS 151

Dr Chas Wells 5276 Park Heights Ave Li 6232

G19041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G19041 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4802 Homer Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4802 Homer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Bryant

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, ~~married~~, widowed, or divorced: Widowed
6 (b) Name of husband or wife: James Bryant
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 9th 1853
8. AGE: Years 91 | Months 4 | Days 5 | If less than one day hr. min.
9. Birthplace Woodbine Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Carter
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Geo. T. Mueller
(b) Address 3000 W. Rogers Ave
17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.
18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.
(c) Date received JUL 16 1944 (d) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1944, at 4:10 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to July 14 1944, and that I last saw h[illegible] alive on July 14 1944.

Immediate cause of death: Hemiplegia — Duration: 3 days
Due to: Artery Sclerosis
Due to: Senility
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury
23. Signature Charles J. Wells M. D.
Address 5276 Park Hts Ave Date signed July 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G19042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19042

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 W Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flounce Jenkins

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Robert Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1884

8. AGE: Years 59 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Housemaid
11. Industry or business

MOTHER / FATHER
12. Name James Gentle
13. Birthplace Ga
14. Maiden Name Mahoney
15. Birthplace Ga

16 (a) Informant James McGuckin
(b) Address 328 S Fulton Ave

17 (a) Burial (b) Date thereof 7/18/44 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Newport, Baltimore Co Md

18 (a) Funeral director William Lee Lee
(b) Address 1217 W Fayette St

19 (a) JUL 16 1944 (Date received by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1944 to 7-15 1944 and that I last saw h alive on 7-15 1944

Immediate cause of death: Uremia — Duration 2 days
Due to: Chronic nephritis
Due to: arteriosclerosis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: [illegible] Lee M. D.
Address Date signed 7/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19043 / 8212 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since July 15, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Kennedy Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWIN R. HOLTZ

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No. 215-10-1133

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna Stocksdale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/1891

8. AGE: Years 52 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER: 12. Name Edwin Holtz; 13. Birthplace Baltimore, Md.
MOTHER: 14. Maiden Name Anna Fowler; 15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Baltimore Co. Md.

18 (a) Funeral director Milton Cockey
(b) Address 1219 E. Saratoga St.

JUL 16 1944 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1944, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1944 to July 15, 1944, and that I last saw h im alive on July 15, 1944

Immediate cause of death: Thrombosis of the basilar artery in the circle of Weltes ~~Due to~~ with a large area of necrosis in the pons — Duration: Unk

Due to: Marked generalized arteriosclerosis — Duration: 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Allison M. D.
Address Baltimore, Md. Date signed 7/15/44

VS 150

Va-14621

G19044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1930

G19044
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Every question answered. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1866 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kaufman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1881

8. AGE: Years	Months	Days	If less than one day
58	1	14	hr. min.

9. Birthplace Fredericksburg Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Geo. E. Newton
13. Birthplace Fredericksburg, Va.

MOTHER
14. Maiden Name Lubine Green
15. Birthplace Fredericksburg, Va.

16 (a) Informant Mrs. J. Roberts
(b) Address 417 Breke St. Alexandria Va.
17 (a) Burial (b) Date thereof 7-18-1930
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's - Hamden
Location Baltimore Md
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street.
19 (a) JUL 16 1930 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1930, at 1:10 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypostatic pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallamaker M.D.
Medical Examiner.
Date signed July 17, 1930.

G19045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19045

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Harwell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Harwell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Percy McKean

3 (b) If veteran, name war

3 (c) Social Security Account No. 075-01-4590

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Elizabeth Ann McKean

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 28th 1890

8. AGE: Years: 53 | Months: 10 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Boston, Mass. (Town, county and state)

10. Usual Occupation: City of Balto.

11. Industry or business: Sewer Inspector

FATHER
12. Name: Thomas McKean
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Celia Corke
15. Birthplace: England

16 (a) Informant: Mrs Elizabeth McKean
(b) Address: 3201 Harwell Ave

17 (a) Burial, cremation, or removal: Burial (b) Date thereof (month) (day) (year): 7/18/44

(c) Cemetery or crematory Location: Baltimore Md

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St Paul st.

19 (a) Filed by registrar (b) Registrar: JUL 16 1944 Washington

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13th 1944, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to July 13 1944; and that I last saw him alive on July 9 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Auricular fibrillation	
Due to Myocardial degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: L B Stevens M. D.

Address: 3400 Eutaw Ave Date signed: 7/19/44

L. B. STEVENS

G19046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19046 Registered No. 74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Severna, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Hoenig

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-1322

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of wife Laura Hoenig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6th 1906

8. AGE: Years	Months	Days	If less than one day
37	11	9	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Bethlehem-Fairfield

FATHER
12. Name Alfred P. Hoenig
13. Birthplace Germany

MOTHER
14. Maiden Name Blanche E. McGee
15. Birthplace Md.

16 (a) Informant Laura Hoenig
(b) Address Severn Md.

17 (a) Burial (b) Date thereof 7/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

JUL 16 1944
(Date rec'd by registrar)

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15 1944 at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1944 to 7-15 1944, and that I last saw him alive on 7-15 1944.

Immediate cause of death	Duration
malignant Fever	
Due to Chr. Lymphoid Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. B. West Jr. M. D.
Address South Balto Gen. Date signed 7-15-44

G. B. West Jr.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G19047 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2866 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2866 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert D Stevenson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: M | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Westminster Md (Town, county, or state)

10. Usual Occupation Lumber Retired

11. Industry or business

FATHER
12. Name John Stevenson
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Anna Stevenson
(b) Address 2866 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 44 (month) (day) (year)
(c) Cemetery or crematory John Hopkins
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 E Pond St

19 (a) JUL 16 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to July 14 1944, and that I last saw her alive on July 13 1944.

Immediate cause of death Pulmonary Embolism — Duration 4 Days

Due to Myocardial Infarction — 6 Wks

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Eric S. Zimmerman M. D.
Address 9858 Sherfield Date signed 7-15

G19048

BALTIMORE CITY HEALTH DEPARTMENT G19048 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: aged Home M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Baddura
3 (b) If veteran, name war W
3 (c) Social Security Account No. none
4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 24, 1860
8. AGE: Years 83 Months 5 Days 21 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Lenders Badders
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Mary Susan
15. Birthplace Baltimore Co Md

16 (a) Informant Sup Methodist Home
(b) Address 2211 Rogers Ave
17. Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Md
Location Pikesville Md
18 (a) Funeral director Wilson Corp Inc
(b) Address 1217 E Baltimore St
19 (a) (Date rec'd by local reg.) (b) Huntington Md

JUL 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 5:00 M
21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944, to July 14 1944, and that I last saw her alive on July 14 44.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to
Due to Arteriosclerosis — 10 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur J Dennis M. D.
Address 8001 W 33rd St Date signed 7-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

G19049

TN. 8893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G19049

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bilz

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jane Bilz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23rd, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

MOTHER / FATHER
12. Name Joseph Bilz
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Brier
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave { Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Location Baltimore Md
18 (a) Funeral director Fulton & Lee Sons
(b) Address 1317 [illegible]

JUL 16 1944 (a) (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22-35 19 to 7-15-44 19, and that I last saw him alive on 7-15-44 19

Immediate cause of death	Duration
Carcinoma of Rectum	umbnown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-12-44

Major findings of operation: Carcinoma of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature S. P. Hasara M. D.
Address Balto City Hosp Date signed 7-15-44

G19050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19050 Registered No.

8-3a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 S. Conkling (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Adamo Tomat

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ wife: late Lucia Tomat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 2 1864

8. AGE: Years 80 | Months 2 | Days 12 | If less than one day: hr. min.

9. Birthplace: Lestanz, Italy (Town, county, and state)
10. Usual Occupation: retired
11. Industry or business

FATHER
12. Name: Tommaso Tomat
13. Birthplace: Italy

MOTHER
14. Maiden Name: Maria Piloni
15. Birthplace: Italy

16 (a) Informant: Antonietta Tomat (Sister in Law)
(b) Address: 221 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 17/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: 4300 Old Frederick Rd.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Morley St.

19 (a) JUL 16 1944 (Date rec'd by registrar) Huntington Mihaus, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14-44 19..., at 7:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12-44 19..., to 7-14-44 19...; and that I last saw h~ alive on 7-14-44 19...

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to: Hypertension, Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.
Address 234 S. Conkling St Date signed 7-15-44

G19051

G19051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Bon Secour Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County .....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2537 E Oliver st
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Louis M. Edelman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary O.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 1 1885

8. AGE: Years	Months	Days	If less than one day
58	9	13	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business B. O. RR.

FATHER
12. Name George Edelman
13. Birthplace ?

MOTHER
14. Maiden Name Catherine —
15. Birthplace ?

16 (a) Informant Mrs Mary O. Edelman

(b) Address 2537 E. Olive St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location .....

18 (a) Funeral director Leonard J. Rusk

(b) Address 5305 Harford Rd

JUL 16 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 1944, at 1 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1944, to 7-14 1944 and that I last saw h[illegible] alive on 7-14 1944.

Immediate cause of death	Duration
Generalized Carcinomatosis (Pancreas - Ca)	
Due to Ca Pancreas & metastasis to liver,	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-28-44

Major findings of operation: Ca of Head Pancreas

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature Louis Vogel Jr. M. D.

Address Bon Secour Hosp. Date signed 7-14-44

VS 3

G19052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19052 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5713 Guyon Oak Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Alton Seim Jr.

3 (b) If veteran, name war No. | 3 (c) Social Security Account No. 216-07-6555

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or, divorced: Married

6 (b) Name of husband or wife: Ella F. Seim

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 6/6/1902

8. AGE: Years 42 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Globe Brewing Co

FATHER
12. Name Charles Alton Seim Sr.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ida Cofer
15. Birthplace Baltimore Md

16 (a) Informant Mrs. C. A. Seim Jr.
(b) Address 5713 Guyon Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto Co. Md.

18 (a) Funeral director C. Willis Lamorelle
(b) Address 4570 Liberty Heights Ave

19 (a) (Name signed by registrar) (b) Huntington Williams M.D.

JUL 16 1944 VS 1/0

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Lee Hollenbeck M.D. (Medical Examiner.)
Date signed July 14, 1944

G19053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 85

G19053

Registered No.

Every item of information should be carefully supplied, write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 N. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Calder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife July 28 1928

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
15	11	18	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Otha Calder
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Mary M Bailey
15. Birthplace Harford Co Md

16 (a) Informant Mary Bailey Calder
(b) Address 1805 N Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-44 (month) (day) (year)

(c) Cemetery or crematory Centre St
Location Forest Hill Md

18 (a) Funeral director Martin Gehrt
(b) Address Jarrettsville Md

19 (a) JUL 16 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 1944, at 10:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Epilepsy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-16-44

G19054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G19054 Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3974 Elm Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3974 Elm Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara E. Hildenfenney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm B. Hildenfenney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Dorthey Bryson
(b) Address 3974 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 1944 (mo.) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Kingsville Md.

18 (a) Funeral director Mahoney & Donovan
(b) Address 3615-17 Eastern Ave.

19 JUL 17 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1944, at 2 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3- 1944 to 7-14- 1944, that I last saw her alive on 7-14- 1944.

Immediate cause of death: Chronic Nephritis — Duration 1 year

Due to:

Due to:

Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in public place)
(e) Means of injury

23. Signature Peter H. Morrissey Jr M.D.
Address 602 Poplar Ave. Date signed 7/15/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 ✓ Registered No. G19055

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3640 Ash St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Ash St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie O. Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Richard A. Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1873

8. AGE: Years 71 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Cornelius Carr.

13. Birthplace Md.

MOTHER 14. Maiden Name Elijah McHenley.

15. Birthplace Md.

16 (a) Informant Clarence L Jackson.

(b) Address 2909 Wellesley Edgemere

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1944 (month) (day) (year)

(c) Cemetery or crematory St Mary's

Location Hampden.

18 (a) Funeral director Glenwood Home

(b) Address 3615-17 Chestnut Ave.

(a) Date received JUL 17 1944 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to 7/15 1944 and that I last saw him alive on 7/15 1944

Immediate cause of death: Coronary Occlusion

Due to Acute Gastro Enteritis

Due to Arteriosclerosis.

Other Conditions Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 8 hrs 2 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 2020 Clark Date signed 7/17/44

G19056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G19056 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3566 Poole St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3566 Poole St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda M. Mason.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: John W. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1874

8. AGE: Years 69 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Samuel Ruby
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Snyder.
15. Birthplace Md.

16 (a) Informant Charles D. Mason
(b) Address 3566 Poole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location Pikesville Md.

18 (a) Funeral director Shenaut & Downes
(b) Address 2615-17 Eastern Ave.

Date rec'd JUL 17 1944 (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1939 to July 15 1944 and that I last saw h[illegible] alive on July 15 1944

Immediate cause of death	Duration
Cerebral Hemorrhage.	7 days.
Due to Cardio-vascular disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 846 W 36th St. Date signed 7/18/44

G19057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55C

Registered No. G19057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & Jones Street

(c) Hospital or institution: Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 ✓

(e) Length of stay in Baltimore (yrs., mos., or days) 66

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3520 Bank St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Clara Jean Van Hagendorp

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife dead William W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 1878

8. AGE: Years	Months	Days	If less than one day
66	4	15 14	12 hr. 30 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Happy Hills School

FATHER — 12. Name dead S J Kirschner

FATHER — 13. Birthplace dead Germany

MOTHER — 14. Maiden Name Sarah Biggar

MOTHER — 15. Birthplace

16 (a) Informant History (Hospital Records)

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director William Lee Inc

(b) Address 12 W Lexington St

19 (a) (b) Huntington Williams Registrar

Date rec'd by Local Registrar JUL 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944, to July 15 1944, and that I last saw her alive on July 15 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Advanced Carcinoma of The Thyroid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Felix Rutledge

Address Women's Hospital Date signed 7/18/44

G19058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19058

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 Boyd Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Boyd Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Hutchinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-05-9019

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen A. Hutchinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4-1895

8. AGE: Years 48 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House painter

11. Industry or business

FATHER
12. Name Thomas K Hutchinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth D.
15. Birthplace Maryland

16 (a) Informant Mrs Helen A Hutchinson
(b) Address 2114 Boyd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19-1944 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore

18 (a) Funeral director George L. Johnson
(b) Address 2101 Frederick Ave

19 (a) JUL 17 1944 (Signature of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1944, at 7— A. M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. T. Wallenmeier M.D. and Medical Examiner.
Date signed 7-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G19059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G19059

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Glenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Glenwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Madden

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gertrude W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1880

8. AGE: Years 64 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name John Madden
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Available
15. Birthplace Ireland

16 (a) Informant Mrs John Madden
(b) Address 711 Glenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-44 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Gaels Md

18 (a) Funeral director Eugene A Feeley
(b) Address Fullerton & Parkville

19 (a) JUL 17 1944 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to July 14 1944, and that I last saw h alive on July 14 1944.

Immediate cause of death Arteriosclerosis — Duration 1940

Due to

Due to

Other Conditions Acute Hemiplegia — 1944

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. N. Bishop M. D.
Address 501 Rhoads Ave Date signed July 17 1944

G19060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93N

Registered No. G19060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 915 S.POTOMAC ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 22 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 915 S.POTOMAC ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM E.RICHARDSON

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: FRANCES RICHARDSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT.15 1879

8. AGE: Years	Months	Days	If less than one day
64	8	29	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business COAST GUARD

FATHER

12. Name JAMES RICHARDSON

13. Birthplace VA.

MOTHER

14. Maiden Name MARYANNA FOSTER

15. Birthplace VA.

16 (a) Informant FRANCES RICHARDSON(WIFE)

(b) Address 915 S.POTOMAC ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 17/44 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Zeiler-Choe.

(b) Address 403 S.WOLFE ST.

19 (a) Date received by Registrar JUL 17 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 14 1944 at 8/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1944 to July 14 1944, and that I last saw him alive on July 13 1944.

Immediate cause of death Hypertension Arteriosclerosis C.V. Disease Cerebral Hemorrhage — Duration: July 9/44

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Ea Schumunck M. D.

Address 842 Bond Date signed 7-14-44

G19061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93N

Registered No. G19061

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 S. Paca St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Josephine Meli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Oscar Meli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27-188

8. AGE: Years 63 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Abraham Georeano

13. Birthplace Italy

14. Maiden Name Grace ——

15. Birthplace Italy

16 (a) Informant Oscar Meli

(b) Address 940 S Paca St

17 (a) Burial [illegible] (b) Date thereof 7-20-44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location A-9 Co.

18 (a) Funeral director Bernard C Hanlon

(b) Address 121 E West

JUL 17 1944

(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1944, at 10 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1944 to 7/16 1944, and that I last saw h[illegible] alive on 7/16 1944

Immediate cause of death Cardiac Failure — Duration

Due to Uremia

Due to Hypertensive C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)

(e) Means of injury

23. Signature R. M. A. Crosby

Address Mercy Hospital Date signed 7/16

VS 180

G19062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94W

Registered No. G19062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dead
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Wolcott Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Seigel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER
12. Name Max Seigel
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-44 (month) (day) (year)
(c) Cemetery or crematory Rodedall
Location Phil. Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

19 (a) JUL 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chas. J. Palmisano M.D.
Medical Examiner.
Date signed 7/15/44

VS 151

G19063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 13 1a

G19063 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Sarasota
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hall Fox

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 10, 1873

8. AGE: Years: 71 | Months: 3 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Trenton, N. J. (Town, county, and state)
10. Usual Occupation: Retired Book Binder
11. Industry or business: U. S. Govt Printing office

FATHER
12. Name: Edward D. Fox
13. Birthplace: Germantown, N. J.

MOTHER
14. Maiden Name: Annie L. Streeper
15. Birthplace: N. J.

16 (a) Informant: Mr. Charles O. Tydings
(b) Address: 4119 Roland Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)
(c) Cemetery or crematory: Greenwood
Location: Trenton, N. J.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Balto Md.

19 JUL 17 1944 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944 to July 15 1944 and that I last saw h[illegible] alive on July 15 1944.

	Duration
Immediate cause of death: Uremic Poisoning	few days
Due to: Chronic Glomerulo Nephritis	four years
Due to: Hypertrophied arteriosclerosis & hypertension	ten years
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Simon V. T. Maddux M. D.
Address 940 W. 39th St Date signed 7-15-44

G19064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 V

Registered No. G19064

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution: West Balt. Gen'l Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Warwick Ave.
(If rural give location)
(e) Citizen of foreign country? Life (Yes or No)
If yes, name country

3 (a) FULL NAME Irene E. Wurz.

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~Wife~~ Frank Wurz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3rd 1900

8. AGE: Years	Months	Days	If less than one day
43	11	13	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George White
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rosa A. Hayes
15. Birthplace England

16 (a) Informant Mr. Frank Wurz
(b) Address 1814 Warwick Avenue.

17 (a) Burial (b) Date thereof July 19th 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Meadowridge Memorial
Location Howard County

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

(a) JUL 17 1944 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16. 19 44, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1944, to 7/16 19 44
and that I last saw h~~e~~r alive on 7/16: 19 44

Immediate cause of death	Duration
Chronic Nephritis.	1 yr.
Due to Hypertensive C.V.D.	
Due to Uremia following Nephritis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.
Address Date signed 7/16/44

G19065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G19065 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Provident

(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 724 N. Carey (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bennie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22/1906

8. AGE: Years	Months	Days	If less than one day
38	4	19	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name unknown

13. Birthplace S.C.

14. Maiden Name Charlotte

15. Birthplace S.C.

16 (a) Informant Elizabeth De Lotch

(b) Address 724 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

19 (a) Registrar (b) Date received JUL 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1944 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to July 11 1944 and that I last saw h alive on July 11 1944

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).) Cerebral Hemorrhage — Duration: 1 day

Due to: Hypertension

Due to:

Other Conditions: Hemorrhoids

(Include pregnancy within 3 months of death)

Date of operation 7-11-44

Major findings of operation: Ulcerated Hemorrhoids

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. Mason Hyggins M. D.

Address 1743 Madison Ave Date signed 7/11/44

G19066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 ✓

Registered No. G19066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 229. S. Green St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S Green St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Clement Haukantas

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 216-05-0309

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Anna Haukantas
(b) Address 229 S. Green St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Beloit Rd

18 (a) Funeral director Joseph Kasinskas Inc
(b) Address 602 Washington Blvd

19 (a) Date received JUL 17 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1944 to July 15 1944 and that I last saw him alive on July 14, 1944

	Duration
Immediate cause of death Auricular fibrillation	days
Due to Chronic valvular heart disease	yrs
Due to Arterio-sclerosis	years
Other Conditions Chronic bronchitis	years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. B. Bromshaw, M.D.
Address 3037 Harnell W Date signed 7-18-44

G19067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 W

G19067
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Md Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes C. Eggert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex f
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife late William H
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 9th 1872
8. AGE: Years 72 Months 3 Days 26. If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name Dennis Cunahugh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O Connor
15. Birthplace Ireland

16 (a) Informant Mrs. Kate G. Jacot
(b) Address 4307 Maine Ave. Forest Park
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Ave.
18 (a) Funeral director John J. Cowan Son
(b) Address 901-03 Gilliss Street.
JUL 17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15 1944, at 8 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1944 to 7-15 1944 and that I last saw h.. alive on 7-15 1944

Immediate cause of death Hypostatic pneumonia — Duration
Due to Fracture at hip
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-13-44 at M
(c) Where did injury occur? Baltimore, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No
(Specify type of place)
(e) Means of injury Fall
23. Signature H B Williams M.D.
Address Medical Examiner Date signed 7/18/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Make correct age is especially important. MARGIN RESERVED FOR BINDING

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 88624 G19068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13h

G19068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1905

8. AGE: Years 38 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Nat Jefferson
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Berger
15. Birthplace Virginia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Arbutus Md
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JUL 17 1944 (Date received by registrar) (b) Huntingtown Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/44 19 , at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1944 to 7/14 1944 and that I last saw h[illegible] alive on 7/13 19 44

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Jarman M. D.
Address BCH Date signed 7/15

G19069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19069

TN. 88591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Laurens St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Clarence Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Dorothy Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1894

8. AGE: Years 50 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Easter Nobles
15. Birthplace N. C.

16 (a) Informant Dorothy Cooper
(b) Address 1316 Laurens St

17 (a) Burial (b) Date thereof July 18, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lucy V. Holland
(b) Address 61 Druid Hill Ave

19 (a) (b) Arlington Williams, M.D.
(Date rec'd by registrar) Registrar

JUL 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1944, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12-44 19 7-15-44 19, and that I last saw him alive on 7-15-44 19.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Cerebral hemorrhage	4 days
Due to H C V D	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeman M. D.
Address B.C.H. Date signed 7/15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G19070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 ✓ Registered No. G19070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 550 Pratman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irvin Scribner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ardella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1894

8. AGE: Years 50 | Months 6 | Days — | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER 12. Name David Scribner

FATHER 13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden Name Mary E?

MOTHER 15. Birthplace Calvert Co. Md.

16 (a) Informant Ardella Scribner

(b) Address 550 Greatman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-44 (month) (day) (year)

(c) Cemetery or crematory Long Green, Md. Location Harford Co. Md.

18 (a) Funeral director Wm. George W. Hall

(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

JUL 17 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1944, at 11 40 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 8 1944 to July 13 1944, and that I last saw deceased alive on July 13 1944.

Immediate cause of death Chronic Nephritis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Bamford, M. D.

Address 550 Pratman St Date signed 7/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

944 N Registered No. G19071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. TYPEWRITE OR PRINT. SPACE RESERVED FOR BINDING. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 Madison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Madison (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Marrow

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband William Marrow
6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo.) June 29 1883

8. AGE: Years 62 | Months 5 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace U. S. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mat Fields
13. Birthplace N.

MOTHER
14. Maiden name Georgia Young
15. Birthplace U. S.

16 (a) Informant William Marrow
(b) Address 2013 Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944
(c) Cemetery or crematory [illegible]
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee V. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JUL 17 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/44 19 3h M

21. I certify that death occurred on the date above stated; that I attended deceased [illegible] 7/14/44, and that I last saw [illegible] 7/14/44.

Immediate cause of death: Pulmonary Embolism
Due to: Coronary Arteriosclerosis
Due to: Diabetes

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard C. Thomas M. D.
Address 501 Park Ave. (Street and number)

VS 150 For D.H.L. Millennium, by (Over) Howard J. Thomas, M.D. 7/17/44

G19072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a Registered No. G19072

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2030 Eagle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 Eagle St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jeschie Max Gittelman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Reverand

FATHER
12. Name Chaim Gittelman
13. Birthplace Russia

MOTHER
14. Maiden Name Ossie Wolfe
15. Birthplace Russia

16 (a) Informant Mrs Regina Starr
(b) Address 2030 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamiltom Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

JUL 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 6

MEDICAL CERTIFICATION 10.45

20. DATE OF DEATH July 16 1944, at P. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an (Autopsy or Inquiry) thereon and from the evidence obtained by said (Autopsy or Inquiry) find that said deceased came to death on the day stated above.

Immediate cause of death Carcinoma of colon — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Wallenmeyer M.D. Medical Examiner.
Date signed 7-12-44

G19073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G19073 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Banger St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Banger St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Thomas Gilley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13. 1944

8. AGE: Years 0 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Edw Thomas Gilley

13. Birthplace Baltimore Md

14. Maiden Name Kathryn V. Siler

15. Birthplace W Va

16 (a) Informant Edw Thomas Gilley

(b) Address 1410 Banger St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location City

18 (a) Funeral director Stoltz & B.M. Walker

(b) Address Pratt & Shroeder St

19 (a) JUL 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 16 1944, and that I last saw living on July 16 1944

Immediate cause of death Premature Birth — Duration 3 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Reyhaner M. D.

Address 2708 Hollins Hollins Date signed 7/16/44

VS 150

~~19074~~ G19074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No. G19074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 W. Cross Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia Wallace

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: PHILIP J. WALLACE
6 (c) If alive, give age 7. years

7. Birth date of deceased (mo., day, yr.) MAY 11 1892

8. AGE: Years	Months	Days	If less than one day
52	2	3	hr. min.

9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business

FATHER
12. Name: HARRY. CREAMER
13. Birthplace: BALTIMORE MD

MOTHER
14. Maiden Name: ELIZABETH PARKER
15. Birthplace: BALTIMORE MD

16 (a) Informant: PHILIP J WALLACE
(b) Address: 624 W. CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) Cemetery or crematory: MT OLIVET
Location: BALTO MD

18 (a) Funeral director: Bernard C Harker
(b) Address: 121 E WEST ST.

19 JUL 17 1944 (Date rec'd by Registrar) (b) Registrar: Hamilton for Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1944 at 10 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: W. L. Wallenmeyer M.D. Medical Examiner.
Date signed 7-17-44

...every item of information should be carefully supplied. The ...correct age is especially important. Physicians: please write the ... PRINT PLAINLY, WITH UNFADING INK.

G19075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19075

TN. 85704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months & 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Albert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1867

8. AGE: Years	Months	Days	If less than one day
77	1	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name George Albert
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Will
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof July 17, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St

18 (a) Funeral director Wendell Riggel
(b) Address 612 S. Hedgewood Ave

19 (Date rec'd by Reg.) JUL 17 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1944 at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30, 43 19 to 7-15-44 19
and that I last saw Mr. alive on 7-15-44 19

Immediate cause of death Bronchio Pneumonia — Duration 1-Wk.

Due to Postoperative

Due to

Other Conditions Arteriosclerotic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation 7/7/44

Major findings of operation Epidermal Carcinoma of Cheek

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. F. Simpson M.D.

Address BCH Date signed 7/15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Penna Ave Apt 303
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Penna Ave Apt 303 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Lois Fletcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-44

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry C Fletcher
13. Birthplace V.C

MOTHER
14. Maiden Name Edna Baker
15. Birthplace V.C.

16 (a) Informant Henry Fletcher
(b) Address 607 Penna ave

17 (a) Burial (b) Date thereof 7-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Pearson
(b) Address 91 Pennsylvania ave

19 (a) JUL 17 1944 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1944 to July 15 1944.
and that I last saw deceased alive on July 15 1944.

Immediate cause of death Pulmonary Atelectasis — Duration 1 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 91 Pennsylvania ave Date signed 7-15-44

G19077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19077
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. O. A.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Stewart
15. Birthplace Md

16 (a) Informant Robert Henson
(b) Address 1205 N. Dallas st

17 (a) Burial (b) Date thereof 7 15 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mulligan & Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date received by registrar) JUL 17 1944 (b) Huntington Md. M.D.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature Hunter J. Fulmer M.D.
Medical Examiner.
Date signed 7/15/44

G19078 G19078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Argyle Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mitchell Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosa

6 (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) 3-30-1923

8. AGE: Years 21 | Months 3 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Chesterfield Co. S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Mitchell
13. Birthplace S.C.

MOTHER
14. Maiden Name Minnie Fuller
15. Birthplace N. C.

16 (a) Informant William Mitchell SR
(b) Address Patrick Route-1- Chesterfield S.C.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) Cemetery or crematory Piney Grove Cemetery
Location Chesterfield County S. C.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) JUL 17 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 9:00 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/15/44 at 23/3 12 05 A M.
(b) Where did injury occur? Hanover & McComas Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? yes
(d) Means of injury Riding a tire on truck & struck by another auto

23. Signature [illegible] M.D. Medical Examiner.
Date signed 7-17-44

VS 151

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 C

G19079 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Wilmington ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Wilmington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve A. Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6410

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 1897

8. AGE: Years 46 | Months 9 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Clk

11. Industry or business Button Co

FATHER
12. Name Otto C Meyer
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Tellmann
15. Birthplace Austria

16 (a) Informant Otto C Meyer
(b) Address 912 Wilmington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Annapolis Rd

18 (a) Funeral director Chas J Kenny
(b) Address Hollins & Gilmor

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to July 15 1944 and that I last saw h.. alive on July 14 1944

Immediate cause of death: Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions: Hernia Endocarditis Sub to acute Rheumatic fever
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Schneeck M.D.

Address 1337 S. Charles St Date signed 7/16/44

4190804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

956

G19080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Burgundy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thelma Wright
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-29-19
8. AGE: Years 25 Months 5 Days 16 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lawrence Williams
13. Birthplace VA

MOTHER
14. Maiden Name Louise Pemberton
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore County, Md
18 (a) Funeral director Joseph A. Lively
(b) Address 4000 Mount Street
19 JUL 17 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 430 A M
21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 15 1944, and that I last saw h[illegible] alive on July 15 1944.

	Duration
Immediate cause of death Cardiac failure	5 weeks
Due to Rheumatic heart disease	- years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Cartwright
Address Johns Hopkins Date signed 7-15-44

G19081

JO #88670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

134a

G19081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lucie H. Wickes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1881

8. AGE: Years	Months	Days	If less than one day
62	10	-1-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Houston Nichols
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucie Houston
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18/44 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Chestertown, Md

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) Filed July 17 1944 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1944 at 6:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23, 1944, to July 15, 1944, and that I last saw her alive on July 15, 1944.

Immediate cause of death Pyelonephritis with uremia. Duration 27d

Due to Bilat. renal calculi

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.
Address BCH Date signed 7/16

G19082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 934

G19082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution:
Mrs. Crawford's Retreat Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2311 Ruskin Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Cornelius A. Drummey

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-9372

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Elizabeth Miller

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept. 7 1870

8. AGE: Years: 73 | Months: 10 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Cornelius Drummey
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Lowden
15. Birthplace: Ireland

16 (a) Informant: Mrs. Elizabeth Drummey
(b) Address: 2311 Ruskin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/19/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: MARTIN FAHEY & SONS
(b) Address: 1827 W. North Ave.

19 (a) JUL 17 1944 (Date received by registrar) Huntington Williams M.D. (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 15 1944 and that I last saw ~~him~~ alive on July 15 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 year
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W. H. Spencer M. D.
Address 1402 E. Lemmle St. Date signed 7-17-44

T.C.P.-6218

G19083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19083

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Payne

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick Payne (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1884

8. AGE: Years 60 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Casper Hart
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Shore
15. Birthplace Pennsylvania

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md

18 (a) Funeral director Unv Berryman & Sons
(b) Address Reisterstown Md

19 (a) (Date received by Registrar) (b) Huntington Hilleary M.D. Registrar

JUL 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1944 19 , at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 19 41, to 7/15 19 44, and that I last saw h[illegible] alive on 7/15 19 44.

Immediate cause of death: Congestive heart failure — Duration ?

Due to: HCVD — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Simpson M.
Address BCH Date signed 7/16

G19085 (X) G19084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 h

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Street.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yancey Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-9-32

8. AGE: Years 12 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Price
13. Birthplace Md.

MOTHER
14. Maiden Name Inez Scarborough
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Harford Co. Md.

18 (a) Funeral director William L. Thomas
(b) Address Darlington Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944 at 1155 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to July 16 1944, and that I last saw h[illegible] alive on July 16 1944.

Immediate cause of death: Cardiac Failure — Duration

Due to Uremia

Due to Congenital renal abnormalities

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp. Date signed 7-17-44

G19085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

Registered No. G19085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 Broadway
(c) Hospital or institution: Church Home + Hosp. 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Delmar ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Baby Girl Twin #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/44

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ray Nichols
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Doris Nichols
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) JUL 17 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1944 to 7-12 1944, and that I last saw h[illegible] alive on 7-12 1944.

Immediate cause of death Atelectasis — Duration

Due to Prematurity (Congenital)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris M. Nichols M.D.

Address CHH Date signed 7/13/44

I 2003

G19086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

G19086
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Broadway
(c) Hospital or institution: Church Home & Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Delmar ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nichols Baby Boy Twin #2
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife 0
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/12/44
8. AGE: Years 0 | Months 0 | Days 1 | If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Ray Nichols; 13. Birthplace Balto, Md
MOTHER: 14. Maiden Name Doris Nichols; 15. Birthplace Va

16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 17 1944
18 (a) Funeral director Commissioner of Health
(b) Address
19 JUL 17 1944 (Date rec'd by registrar) (Signature of) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12- 1944 at 7:20 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-12- 1944, to 7-12 1944, and that I last saw him alive on 7-12 1944.

Immediate cause of death Atelectasis — Duration
Due to Prematurity (approx. 6 mos)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Marion M Fackler
Address CHH Date signed 7/13/44 M.D.

2002

G19087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√83a

G19087 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked by the informant. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Memorial 1336
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3337 Falls Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice McVan Dyke

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Norris N. VanDyke

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): July 25 1889

8. AGE: Years 54 | Months 11 | Days 21 22 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Emanuel Teal
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Alice Ryson
15. Birthplace: ?

16 (a) Informant: Norris N. VanDyke
(b) Address: 3337 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory: St Marys
Location: Hampden

18 (a) Funeral director: Rhinowitz & Damann
(b) Address: 340 N Schroeder Ave.

(c) JUL 17 1944 (Local registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to: Arteriosclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed July 17, 1944

G19088

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH √61

G19088
Registered No.

JO #89019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Eastern Ave., Essex
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stahlheber (Stahelheber)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 165-18-6094

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1919

8. AGE: Years 25 | Months -3- | Days 22 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Iron Construction

11. Industry or business

FATHER
12. Name Wilbert (d)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Matilda Rentscher
15. Birthplace Pennsylvania

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/17/44 (month) (day) (year)
(c) Cemetery or crematory Scranton Penn Pa
Location Scranton Pa

18 (a) Funeral director Philip Stewart Sons Inc
(b) Address 2024 Orleans St

19 (a) (Date received by Local Registrar) (b) JUL 17 1944 Registrar Huntington Willmouth, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1944, at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16-44 19... to 7-16-44 19..., and that I last saw him alive on 7-16-44 19...

	Duration
Immediate cause of death: Diabetic Coma	10 hrs.
Due to: Peripheral circulatory failure	1 hr.
Due to:	
Other Conditions: Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M.D.
Address B C H Date signed 7/17

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19089

G19089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 Club Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Club Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice B. Gallagher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Dr. Harry P. Gallagher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1870

8. AGE: Years	Months	Days	If less than one day
73	11	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. E. Broderick
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Jane Mullen
15. Birthplace Md

16 (a) Informant Mrs. Mary B. Winand
(b) Address 1603 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1944 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) 7/17/44 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 1944, at 11:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial degeneration

Due to

Other Conditions Angina Pectoris

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 7-16-44

G19090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19090 Registered No. X 55 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 300 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 300 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State No Carolina (b) County
(c) City or town Charlotte, 3 (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Berkeley Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Edith B Brown

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Neil H. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1891

8. AGE: Years 53 | Months 0 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace: Lucite, Kansas (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name C. D. Blanchard
13. Birthplace Illinois

MOTHER
14. Maiden Name Belvia Cornwell
15. Birthplace Illinois

16 (a) Informant Mr. Neil H. Brown
(b) Address 908 Berkeley St. Charlotte, N.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 17th 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Charlotte, N. C.

18 (a) Funeral director Wm. J. Tickner & Sons.,
(b) Address North & Penna Aves.

19 (a) Date of burial JUL 17 1944 (b) Hamilton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1943 to July 16 1944, and that I last saw her alive on July 16 1944.

Immediate cause of death: Sarcoma, osteogenic with metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Diagnosis confirmed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Brumbaugh Jr. M. D.
Address 332 E. University Pkwy Date signed 7/17/44

G-19090½

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G-19090½ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 215 S. Regester St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby John~~son~~ Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/15/44 Premature

8. AGE: Years	Months	Days	If less than one day
~~Premature~~			2 hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John M. Ford

FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Elsie Wieczorkowska

MOTHER 15. Birthplace Balto Md

16 (a) Informant John Wieczorkowski

(b) Address 215 S. Register St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Rd

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern Ave

JUL 17 1944 (Date received) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1944, at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1944 to 7/15 1944 and that I last saw h~~im~~ alive on 7/15 1944.

Immediate cause of death ~~Premature~~ atelectasis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Fred E. Hodes M.D.

Address 1400 N. Caroline St Date signed 7/16/44

G19091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 343 Montingale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Montingale Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Adeline Willis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1861

8. AGE: Years	Months	Days	If less than one day
83	2	10	hr. min.

9. Birthplace Boston Mass
(Town, county, and state)

10. Usual Occupation Retired Housewife

11. Industry or business

FATHER
12. Name Julius Parrett
13. Birthplace America

MOTHER
14. Maiden Name Adelade Courtot
15. Birthplace France

16 (a) Informant Brand E. Willig
(b) Address 343 Montingale Ave

17 (a) Burial (b) Date thereof July 18 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director George L. Schwat
(b) Address 2101 Edmondson Ave.

19 JUL 18 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 9 56 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1944 to July 15 1944, and that I last saw ~~her~~ alive on July 13 1944.

Immediate cause of death: Heart Failure
Coronary Thrombosis

Duration

Due to

Due to

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris C. Nitch M. D.
Address 2151 Wellesley Date signed 7/17/44

G19092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G19092

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 S Potomac St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 S Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cathrine Jungbauer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Oscar
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1868
8. AGE: Years: 76 Months: Days: If less than one day: hr. min.
9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant: Sophie Brost
(b) Address 29 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd

18 (a) Funeral director: Joseph Kaumakos Jr.
(b) Address 602 Washington Blvd.

19 (a) (Date received) (b) Registrar
JUL 18 1944 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944, to July 17 1944, and that I last saw her alive on July 12 1944.

Immediate cause of death	Duration
Cerebral Hemmorage	1 day
Due to Hypertension	10 yrs?
Due to Arteriosclerosis	10 yrs?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Daresh M. D.
Address 2530 E. Baltimore St. Date signed 7/17/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Every item of information should be carefully supplied. The blanks write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G19093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#67

G19093 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 W Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 W Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles J Skinkis

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 215-16-6258

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Madgelin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Anna Griffin
(b) Address 2609 W Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balt Md

18 (a) Funeral director Joseph Kasunakas Sons
(b) Address 602 Washington Blvd Huntington Station, Md.

19 (a) Date received by Local Registrar JUL 18 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 4 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 7/17 1944, and that I last saw him alive on 7/9 1944

Immediate cause of death: Carcinoma of Liver — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alpha H. Emorton M. D.

Address 409 Fred ave Date signed 7/17/44

G19094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19094 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hospital
(c) Hospital or institution Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) never

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Johnstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 1289 Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Margaret Hershberger.

3 (b) If ~~veteran, name~~ war

3 (c) ~~Social Security~~ Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife W. C. Hershberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1878

8. AGE: Years 65 66 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Bedford Co. Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Hoon

13. Birthplace Pa.

MOTHER 14. Maiden Name Lydia Conley

15. Birthplace Unknown

16 (a) Informant

(b) Address 1289 Franklin St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)

(c) Cemetery or crematory Location Johnstown Pa

18 (a) Funeral director Harry H. Witzke

(b) Address 4816 E Emerson Ave

19 (a) JUL 18 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944, to July 17 1944, and that I last saw ~~s~~ alive on July 11 1944

Immediate cause of death	Duration
Pneumonia	
Due to Dilitation of stomach?	
Acute gangrenous Gall Bladder	
Due to Chronic cholelithiasis & cholecystitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren M. Nachlas, M.D.

Address Church Home & Hosp. Date signed 7/18/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X L 74a R. G19095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 6/26/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 6/26/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Deals Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC JAMES JONES

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1884

8. AGE: Years 59 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Deals Island, Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Merchant Marine

FATHER
12. Name Alfred Jones
13. Birthplace Deals Island, Md.

MOTHER
14. Maiden Name Learah Bivens
15. Birthplace Deals Island, Md.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17-44 (month) (day) (year)
(c) Cemetery or crematory Deals Island Cem.
Location Deals Island Md.

18 (a) Funeral director F. B. Hill
(b) Address Salisbury Md.

19 JUL 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH July 17, 1944, at 3:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26, 1944, to July 17, 1944, and that I last saw him alive on July 17, 1944.

Immediate cause of death Chronic lymphatic leukemia — Duration Since 6/1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 7/14/44; Thoracentis
Major findings of operation: As above

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl T. Johnson M. D.
Address Baltimore, Md. Date signed 7/17/44

VS 150

MS-53800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N Janney St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Janney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Hartley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1876

8. AGE: Years 67 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Station Engineer

11. Industry or business Paul Jones Distillery Co

FATHER
12. Name Daniel Hartley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Emery
15. Birthplace Balto. Md.

16 (a) Informant Ida M. Hartley
(b) Address 123 N. Janney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19-44 (month) (day) (year)
(c) Cemetery or crematory Leswid Ridge Cem
Location Pikesville Md

18 (a) Funeral director John G Moran
(b) Address 3000 E Baltimore St

JUL 18 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944 at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H Z Wallenmeyer M.D. Medical Examiner.
Date signed July 17, 1944

G19097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 99 ✓

Registered No. G19097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAS.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S. Taylor, Essex
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bley

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-01-3310

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: ANNA L. BLEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 28 1892

8. AGE: Years 52 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace HOLLAND
(Town, county, and state)

10. Usual Occupation SEAMAN

11. Industry or business

FATHER
12. Name JOHN BLEY
13. Birthplace HOLLAND

MOTHER
14. Maiden Name GESBERDINA BYK
15. Birthplace HOLLAND

16 (a) Informant ANNA L. BLEY (WIFE)
(b) Address 100 S. TAYLOR AVE. ESSEX

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 20/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zecher Sons
(b) Address 403 S. WOLFE ST.

19 (a) Date received JUL 18 1944 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 16 1944 and that I last saw h. i. m. alive on July 16 1944

Immediate cause of death: Cardiac Failure — Duration

Due to: Myocardial Thrombosis & Embolism

Due to:

Other Conditions: Rt. Hemiplegia. Endocarditis

(Include pregnancy within 3 months of death)

Date of operation: Post mortem only 7/16

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Gerhleman M. D.

Address University Hosp. Date signed July 16 1944

G19098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

918

G19098

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 735 Hover
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Hover (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hezekiah Lewis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1886

8. AGE: Years 58 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Marble Yard

FATHER
12. Name George T. Lewis
13. Birthplace Va

MOTHER
14. Maiden Name Agnes ?
15. Birthplace Va

16 (a) Informant Alberta Shannon
(b) Address 735 Hover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 18 44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1944 W Montgomery St

19 JUL 18 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to July 15 1944, and that I last saw h[illegible] alive on July 15 1944.

Immediate cause of death

Due to Acute Endocarditis

Due to

Other Conditions Cyst

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Caplan M. D.
Address 1816 E. Eager St Date signed 7-18-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAYOR'S RESERVED FOR BINDING

G19099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 g

G19099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINTED FOR LOADING

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution University Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balte
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Luzerne St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Knoche

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Caroline Knoche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Louis Knoche
13. Birthplace

MOTHER
14. Maiden Name Eliz. Fisher
15. Birthplace

16 (a) Informant Mrs Carrie Knoche
(b) Address 419 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Windsor Mill Road

18 (a) Funeral director Lilly & Lenard Home
(b) Address 2008 Orleans St

19 (a) [illegible] (transcription) Huntington Williams, M.D. Registrar

JUL 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16-44 19... at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-44 19... to 7-16-44, and that I last saw h.e.M. alive on 7-16-44 19...

Immediate cause of death Cardiac failure — Duration

Due to Hydrothorax

Due to Metastatic Ca of Pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Stanton Abel, M.D. M. D.

Address Univ. Hosp. Date signed 7-17-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19100 ✓ G19100 Registered No.

G19100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DEceased:
(a) State Md (b) County
(c) City or town Wexford (If outside city or town limits write RURAL and give town)
(d) Street No. 2104 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel W. Carrick

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-4955

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 30-1877

8. AGE: Years 66 | Months 9 | Days 17 16 | If less than one day ... hr. ... min.

9. Birthplace Penn Township Co Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Elliott Machine Co.

FATHER 12. Name J Carrick

13. Birthplace Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs Emma Carrick

(b) Address 2104 Sidney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19-44 (month) (day) (year)

(c) Cemetery or crematory London Pk.

Location Balto Md

18 (a) Funeral director Geo J Lemmon

(b) Address 525 N Eutaw St

19 (a) JUL 18 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1944, at 805 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1944 to 7/16 1944 and that I last saw h.im alive on 7/16/1944.

Immediate cause of death Carcinoma of Ascending Colon & generalized metastasis — Duration

Due to — Duration

Due to — Duration

Other Conditions Acute Appendicitis — Duration

(Include pregnancy within 3 months of death)

Date of operation 7/10/44

Major findings of operation: Carcinoma Ascending Colon & General metastasis. Acute Appendicitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm T. Muse M. D.

Address St. Agnes' Hosp. Date signed 7/16/44

G19101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REQUIRED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden Ave
(c) Hospital or institution: Md. Genl. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 852 Powers St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Chas. Dunson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Grace Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1880

8. AGE: Years 63 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Geo. M. Shannon
(b) Address 852 Powers St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20-44 (Month, day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Geo. E. Boyer Jr.
(b) Address 1512 Hollins St

19 (a) JUL 18 1944 (Date received by registrar) Huntington Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17/ 1944, at 3:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16/1944, to 7/17/1944, and that I last saw him alive on 7/17/1944.

Immediate cause of death Cardiac failure — Duration
Due to Coronary thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Md. Gen. Hosp. Date signed 7/18/44

G19102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E S.S. Sonora Eastern Transport Co

Registered No. G19102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Curtis Bay
(a) State (b) County
(c) City or town Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. S.S. SONORA
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Ah Cheung

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Chinese	Married

6 (b) Name of husband or wife Could not ascertain

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
about 39			hr. min.

9. Birthplace China
(Town, county, and state)

10. Usual Occupation Cook on above ship.

11. Industry or business (Shipping)

FATHER
12. Name Could not ascertain
13. Birthplace China

MOTHER
14. Maiden Name Could not ascertain.
15. Birthplace China

16 (a) Informant Chao Ming Chen (Friend)
(b) Address 339 E. 29th St., Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Sleasman Brothers Co.
(b) Address 1081 W. Lombard St. Balto. Md.

19 JUL 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestion Cardiac Failure

Due to

Other Conditions Acute Pulmonary Edema & Congestion; Acute Congestion of all viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 7-17-44

G19103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G19103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Warwick (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph ~~Isaac~~ Dragon

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Israel Dragon
13. Birthplace Russia

MOTHER
14. Maiden Name Celia Isaacs
15. Birthplace Russia

16 (a) Informant Bennett Dragon
(b) Address 1459 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) Cemetery or crematory Russedale
Location.....

18 (a) Funeral director Jos Levin Inc
(b) Address 1439 E. Balto. St

19 (a) JUL 18 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 11:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature W. L. Wallenmeyer M.D.
Deputy Medical Examiner.
Date signed 7-17-44

(over)

G19104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

G19104
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city limits, write RURAL and give town)
(d) Street No. 2013 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Goldberg

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 — Months — Days — If less than one day: hr. min.

9. Birthplace Russia (Town, county, or state)

10. Usual Occupation Tailor (self)

11. Industry or business

FATHER — 12. Name Isaac
13. Birthplace Russia

MOTHER — 14. Maiden Name Sag
15. Birthplace Russia

16 (a) Informant Gertrude Goldberg
(b) Address 2013 E. Fairmount ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew
Location Rosedale

18 (a) Funeral director Jack Lewis Inc
(b) Address 409 E. Balto. St

19 (a) JUL 18 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to July 17 1944 and that I last saw h[illegible] alive on July 17 1944

Immediate cause of death: Phlebo-Thrombosis of Left leg with Gangrene & Phlebitis — Duration: 6 mos

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reuben Cooper M. D.
Address 407 Park Ave Date signed 7/19/44

VS 180

G19105
J0 87380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

516

G19105
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. Calhoun (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Mary Jones (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1884

8. AGE: Years	Months	Days	If less than one day
60	-0-	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Jones (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Cole (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) Cemetery or crematory mt auburn
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pressstman St

(a) JUL 18 1944 (b) Washington Boulevard, Md.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1944, at 5:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 10, 1944, to July 14, 1944, and that I last saw him alive on July 14, 1944.

Immediate cause of death	Duration
Uremia	7 days
Due to Carcinoma of prostate with metastasis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6-9-43
Major findings of operation: Orchidectomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hauck E. Belton M. D.
Address Balt. City Hosp. Date signed 7/18/44

G19106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G19106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age if especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4304 Penhurst Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Rhoda Margaret Christopher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William J. Christopher

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) January 21, 1871

8. AGE: Years 73 | Months 5 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Laurel, Delaware
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name I. J. Collins
13. Birthplace Laurel, Delaware

MOTHER
14. Maiden Name Sarah Cordrey
15. Birthplace Laurel, Delaware

16 (a) Informant Miss Frances M. Christopher
(b) Address 4304 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cemetery
Location Laurel, Delaware

18 (a) Funeral director Wilkins Lamborn
(b) Address 4510 Liberty Heights Ave.

19 JUL 18 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 12.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to July 16 1944, and that I last saw h. er alive on July 16 1944.

Immediate cause of death	Duration
Cardiac Fibrillation	
Due to	
Due to	
Other Conditions Pancreatic cyst with nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. S. Stewart M.D.
Address 2329 Arunah Ave. Date signed 7/17/44

G19107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944 Registered No. G19107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 Rutland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

8-16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: John Martin Weiman

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 220-07-0138

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth Folson

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 31, 1884

8. AGE: Years 59 | Months 11 | Days 17/6 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Industrial Bldg

FATHER
12. Name John Baptist Weiman
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Laura V. Everett
15. Birthplace Balto. Co. Md

16 (a) Informant Mrs. Ruth F. Weiman
(b) Address 1619 Rutland Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7-20-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address North Ave. & Broadway

17 (b) Date received JUL 18 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 1.55 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 25, 1944 to July 17 1944, and that I last saw him alive on July 15, 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage &	
Spastic paralysis	5 days
Due to: Arteriosclerosis	6 Mos.
Due to:	
Other Conditions Chronic Myocarditis	6 Mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert G. Dingwerth
Address 1613 E. North Ave. Date signed 7-17-44

G19108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

146d Registered No. G19108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. REMOVE FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution: Redwood & Arm St. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA HERZOG MANSBACH

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None
4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jerome H. Mansbach
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 10, 1872
8. AGE: Years 72 | Months 4 | Days 7 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Charles Herzog
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Josephine Schwartz
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. LeGarde Jones
(b) Address 2201 Maryland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7- - 44 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom Congregation
Location Baltimore

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway
(c) Date received by registrar JUL 18 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-44 19 at 9:03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1944, to 7-17 1944, and that I last saw h.e.r. alive on 7-17 1944.

Immediate cause of death: Myocardial Failure — Duration: 8 mo.
Due to: Carcinoma of Rectum
Toxicity
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.
Address Sinai Hosp. Date signed 7-17-44

G19109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G19109

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospt. U.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Summer Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-9330

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Emma Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Sarah Jones
(b) Address 105 N. Bond St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Waldron
(b) Address 1000 Bryant Ley

19 (a) JUL 18 1944 (Date rec'd by registrar) per Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 3 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobular primary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed July 17, 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a Registered No.

G19110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution: 1514 Division St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Brunt St
(If rural give location)
(e) Citizen of foreign country? none (Yes or No)
If yes, name country

3 (a) FULL NAME William Brayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Brayton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1886

8. AGE: Years 57 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Cumberland Co. Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Bessie Brayton

(b) Address 1909 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 7-18-1944 (Date received by Local Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15 — 1944, at 4:05 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 — 1944, to 7-15 — 1944, and that I last saw him alive on 7-15 — 1944

Immediate cause of death: Intestinal Obstruction — Duration

Due to: Strangulated

Due to: Incarcerated Right Inguinal Hernia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-15-44

Major findings of operation: Gangrene Jejunum & Omentum in hernia

Autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. B. Jackson

Address Provident Hosp. Date signed 7/18/44

G19111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57d

Registered No. G19111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. RESERVED FOR BINDING

1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ?

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4982 ~~Monument~~ Ave (If rural give location)

(e) Citizen of foreign country? Denmark (Yes or No)
If yes, name country .....

3 (a) FULL NAME Barbara Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1940

8. AGE: Years 4 | Months 3 | Days 27 | If less than one day ..... hr. ..... min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Early F. Johnson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret M Keogh
15. Birthplace Balto. Md.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Lorings Bros
(b) Address 5005 Park Heights Ave Balto Md

JUL 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944 at 5 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to July 16 1944 and that I last saw h. alive on July 16 1944.

Immediate cause of death: Brain Tumor — Duration ?

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 4 mos ago

Major findings of operation: Brain Tumor

of autopsy: Brain Tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature Nancy V. Ryggle M. D.

Address Johns Hopkins Hosp Date signed 7-19-44

VS 160

G19112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940

Registered No. G19112

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2273 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Girard Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Strong

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Blanche E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 25 1871

8. AGE: Years 73 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace: Chesterhurst N.J. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Charles Strong
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Jane E. Strong
(b) Address: 2273 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)
(c) Cemetery or crematory: Northwood Cem
Location: Philada. Pa.

18 (a) Funeral director: Loring Byers
(b) Address: 5005 Park Heights Ave

19 JUL 18 1944 (Date rec'd by registrar) (b) Huntington Williams Register

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1944 at 7:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.
Date signed 7/19/44
Per. Howard T. Maddux, M.D.

RATTINI

G19113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in spaces RESERVED FOR BINDING. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hospital
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Leonard Rattini
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Carmella -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1889

8. AGE: Years 55 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business Balto. Transit Co

FATHER
12. Name Vincenzo Rattini
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Cappely Grande
15. Birthplace Italy

16 (a) Informant Maria Rattini wife
(b) Address 220 S. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Orleans Road.

18 (a) Funeral director Frank Ellis Noce
(b) Address 52 W. Mosher St.

19 (a) Registrar (b) Huntington Ave. Registrar

JUL 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17/1944 at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6/1944 to 7/17/1944 and that I last saw h[illegible] alive on 7/17/1944

Immediate cause of death Liver (Hepatic) Insufficiency Duration
Due to Peritonitis. Duration
Due to Chronic Cholecystitis - Duration
Pericholecystic Adhesions Duration
Due to Duration
Other Conditions Duration
(Include pregnancy within 3 months of death)

Date of operation 7/13/44
Major findings of operation: Pericholecystic adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St. Joseph's Hospital Date signed 7-17-44

G19114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G19114 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 E Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Anna Maloney
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James Maloney
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) March 5 1923

8. AGE: Years	Months	Days	If less than one day
21	4	11	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Norman F. Hoffheuer
13. Birthplace Maryland

MOTHER
14. Maiden Name Antonetty Dumbra
15. Birthplace Italy Md.

16 (a) Informant Norman F. Hoffheuer
(b) Address 2016 Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-44 (month) (day) (year)
(c) Cemetery or Crematory Oakhill Cem.
Location Balto. Md.

18 (a) Funeral director John F. Miller Inc.
(b) Address 2435 E Oliver St

19 (Date rec'd by registrar) JUL 18 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16-1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1944, to July 16 1944, and that I last saw her alive on July 15th 44

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph Pokorny M. D.
Address 2200 E Madison Date signed 7/17/44

VS 150

a 35924

G19115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19115
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Use full name of city or county. If birthplace or usual residence is outside the United States, name the country instead of the state. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr. Geo's Co.
(c) City or town Brandywine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-35

8. AGE: Years	Months	Days	If less than one day
9	4	20	hr. min.

9. Birthplace D.C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER — 12. Name William A. Lee

13. Birthplace Md

MOTHER — 14. Maiden Name Alice Marshall

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof July 21 44 (month) (day) (year)

(c) Cemetery or crematory St. Thomas'

Location Aquasco, Md

18 (a) Funeral director Andrew J. Gross

(b) Address Aquasco, Md.

19 JUL 18 1944 (b) (Date received by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944 at 8:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to July 17 1944 and that I last saw he alive on July 17 1944

Immediate cause of death	Duration
(a) Respiratory failure	
Due to (b) Hodgkins	
Due to (c) Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye Wood

Address Dr Date signed

G19116 BALTIMORE CITY HEALTH DEPARTMENT G19116
CERTIFICATE OF DEATH 16 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene Sts
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Charles Weber
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/7/44

8. AGE: Years | Months | Days 6 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Charles Weber
13. Birthplace West Virginia

MOTHER
14. Maiden Name Ruby Bader
15. Birthplace —

16 (a) Informant Ruby Weber
(b) Address 620 W. Lexington St

17 (a) Burial. (b) Date thereof 7/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral.
Location —

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] (b) JUL 18 1944
(Signature of registrar) Registrar

V8 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1944 at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944 to 7/15 1944, and that I last saw h[illegible] alive on 7/15 1944.

	Duration
Immediate cause of death Resp. failure	1 Day
Due to Dehydration	4 days
Due to —	
Other Conditions Sclerema	1 day

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Alfred J. Nelson M. D.
Address University Hosp. Date signed 7/15/44

G19117 56693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Wilmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 French St National Theatre
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Skinner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 ? 06

8. AGE: Years	Months	Days	If less than one day
38	3		hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Skinner
13. Birthplace S.C.

MOTHER
14. Maiden Name Merrill ?
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 18 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 1:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1944, to July 8 1944, and that I last saw him alive on July 8 1944

Immediate cause of death ~~Respiratory failure~~

Due to Tuberculosis of pericardium 1 year

Due to Pulmonary tbc. 3 mos

Other conditions Tbc. enteritis 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Cunningham M. D.
Address JHH Date signed 7/8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

2004

G19118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G19118

AB-29056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs 6 mos 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Briggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30-1887 ?

8. AGE: Years	Months	Days	If less than one day
67?	9-	11?	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace Virginia

MOTHER
14. Maiden Name Missouri Briggs
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 18 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11- 1944 at 6.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/28 1940 to 7/11 1944, and that I last saw h[illegible] alive on 7/11 1944

Immediate cause of death	Duration
Bronchopneumonia	1 wk.
Due to Cerebral Palsy	?
Due to	
Other Conditions HCVD	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Shea Halle
Address Balt city Hosp Date signed M. 7/18/44 D.

2005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REGION RESERVED FOR BINDING

G19118 457045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G19119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 S. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad F. Einsehutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ronna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-94

8. AGE: Years 50 | Months 3 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business

FATHER
12. Name Ferdinand Einsehutz
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Shay
15. Birthplace Germany.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

19 (a) ... (b) Huntington for Williams, M.D.
(Local Registrar) Registrar

JUL 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944 to July 16 1944 and that I last saw him alive on July 16 1944

Immediate cause of death Mediastinitis & empyema — Duration

Due to Infection of lower esophagus, upper stomach for carcinoma

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/13/44.

Major findings of operation Carcinoma of cardia, extending into esophagus

of autopsy ... growth of esophageal ... & mediastinum & empyema

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Lou W. Saunders

Address Johns Hopkins Hosp. Date signed 7/17/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G19120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G19120
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital. Out dispensary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs (?)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Tufilli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1880

8. AGE: Years	Months	Days	If less than one day
64	23	7	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Andy Tufilli
13. Birthplace Italy

MOTHER
14. Maiden Name Mary (?)
15. Birthplace Italy

16 (a) Informant Mary Hartter
(b) Address 2021 Maryland ave.

17 (a) Burial (b) Date thereof 7-20 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary Mc Vaudeveld
(b) Address 201 E. 22nd St

19 (a) Date received by registrar JUL 18 1944 Wallington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1944 at 2.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on July 14 1944.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M. D.
Address Union Date signed

G19121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19121
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Bramhall Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June, 1923

8. AGE: Years 21 | Months 1 | Days | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business

FATHER
12. Name Lorenza Williams
13. Birthplace N. C.

MOTHER
14. Maiden Name Essie Perry
15. Birthplace N. C.

16 (a) Informant Ellen Williams
(b) Address 617 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/44 (month) (day) (year)
(c) Cemetery or crematory Newport News
Location Virginia

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Huntington Williams, M.D. (Date received by registrar)

JUL 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 7:45 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 16, 1944 5:15 P.M. 25/6 P.
(b) Where did injury occur? Arundel Sand & Gravel Co.
(c) Did injury occur at Home, on farm, industrial place, in public place? Industrial While at work? No
(d) Means of injury Drowning - swimming

23. Signature H. L. Wollenweber M.D.
Asst. Medical Examiner.
Date signed 7-17-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19122
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Dorchester Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Culotta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Marian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13 1886

8. AGE: Years 57 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Wholesale Fruit

11. Industry or business Dealer

FATHER
12. Name Frank Culotta
13. Birthplace Italy

MOTHER
14. Maiden Name Not Available
15. Birthplace Italy

16 (a) Informant Mrs. Vincent Culotta
(b) Address 700 E Dorchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-44 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director George C Feeley
(b) Address Fulton & Forrest

19 JUL 19 1944 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1944 at 10:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1944 to 7/16 1944, and that I last saw him alive on 7/16 1944

Immediate cause of death Hypostatic Pneumonia — Duration 2 da.

Due to Carcinoma of liver ? — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/8/44

Major findings of operation: Carcinoma of liver ? Ascites

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 7/17/44

G19123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19123
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W. 21st st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 W. 21st st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Dalmus

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~or wife~~: Philip C. Dalmus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23rd 1865

8. AGE: Years 79 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Harrisburg Pa.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Jacob C. Gray
13. Birthplace Delaware

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace Harrisburg Pa.

16 (a) Informant Philip C. Dalmus
(b) Address 18 W. 21st st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 1944 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date received by local registrar) Huntington Williamsport
JUL 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16th 1944; at 5:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1937 to July 16 1944 and that I last saw h~~er~~ alive on July 16 1944

Immediate cause of death: Cerebral hemorrhage. — Duration 10 days
Due to: arteriosclerosis — History about 10 yrs.
Due to:
Other Conditions: Diabetes Mellitus — History 15 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Ward Wisner M.D.
Address 2125 Maryland Date signed 7/17/44

G19124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G19124 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Parkside Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte L. Lutz

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1894

8. AGE: Years 50 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robin Lloyd
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ?
15. Birthplace Baltimore, Md.

16 (a) Informant Eugene Lutz
(b) Address 3902 Parkside Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)
(c) Cemetery or crematory Morsland Park
Location Baltimore Co., Md.

18 (a) Funeral director Wm Cook Sons
(b) Address 1217 St. Paul St

19 JUL 19 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1944, at 11:15 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Woellmueller M.D.
Medical Examiner.
Date signed July 17, 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19125 BERWAGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 V

G19125 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Stafford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Stafford St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John L. Berwager

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sabina Sherman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1855

8. AGE: Years	Months	Days	If less than one day
89	6	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Not known
13. Birthplace "

MOTHER
14. Maiden Name Not known
15. Birthplace "

16 (a) Informant J. H. Berwager
(b) Address Baltimore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/44 (month) (day) (year)
(c) Cemetery or crematory Leister's Cemetery
Location Carey County, Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) JUL 19 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 44 to 7/19 19 44, and that I last saw living alive on 7/19 19 44.

Immediate cause of death Arteriosclerotic carotid vascular disease — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 30 Wilkens Ave Date signed 7/19/44

G19126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 W

Registered No. G19126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204. Wilcox. St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Wilcox St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Rossiter.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1876

8. AGE: Years	Months	Days	If less than one day
67 68	9/10		hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Produce
11. Industry or business

FATHER
12. Name John Rossiter
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Burke
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Annie Rossiter
(b) Address # 1204 Wilcox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July, 20 1944 (month) (day) (year)
(c) Cemetery or crematory New Catherdral Cem
Location Frederick Rd.
18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N. Wolfe St.
19 (a) (Date of death) (b) Huntington Williams M.D.

JUL 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17th 1944, at 7. P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1944, to 7/17 1944, and that I last saw h/m alive on 7/16 1944

Immediate cause of death Arteriosclerotic Cardio Vascular Renal disease — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Bloom M.D.
Address 1266 E. Preston St Date signed 7/18/44

OGURECK. ✓

G19127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 ℓ

G19127 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ALL RIGHTS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Newington Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kalman Ogureck.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-3186

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Warsaw Poland
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Mollie Ogureck
(b) Address 810 Newington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 439 E. Balto St.

19 (a) JUL 19 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1944 at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1944 to July 18 1944, and that I last saw him alive on 7/17 1944.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Hypertensive Card. Vas. Renis	
Due to Cancer Jaw Neck	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Williams M.D.
Address Sinai Hosp. Date signed 7/18/44

G19128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46b

G19128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John Street
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 81 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN L. HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Claude H. Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1875

8. AGE: Years 68 | Months 9 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Edgar Lazarus
13. Birthplace South Carolina

MOTHER
14. Maiden Name Miss ~~Minnie~~ Mordecai
15. Birthplace ~~the~~ South Carolina

16 (a) Informant Miss ~~Hall~~ Lazarus
(b) Address 1600 Park Ave. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20/44 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Section 2 Lot 0 Range 2

18 (a) Funeral director John O. Hatfull Sons
(b) Address 1900 Eutaw Place

19 (Filed) JUL 19 1944 (Signature) Registrar Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944 at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1944 to July 17 1944 and that I last saw her alive on July 17 1944.

Immediate cause of death Respiratory failure — Duration 2 hours

Due to Carcinoma of stomach

Due to

Other Conditions Extreme cachexia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie J. Lewis M.D.
Address Hosp. for Women of Md. Date signed 7/17/44

(OVER)

G19129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13b

G19129 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 STERRETT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 STERRETT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH GRUBE

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-1012

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife EDITH O. GRUBE

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Oct 29 1875

8. AGE: Years	Months	Days	If less than one day
68	8	19	hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business Swindler Bro.

FATHER — 12. Name HENRY GRUBE
13. Birthplace GERMANY

MOTHER — 14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant EDITH GRUBE
(b) Address 1104 STERRETT ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Bernard O Hahn
(b) Address 121 E West St

(a) JUL 19 1944 (Registrar) (b) Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 18 1944, at 945 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 to July 18 1944.
and that I last saw h alive on 19

Immediate cause of death: Bilateral Pulmonary Tuber - culosis — Duration: 2 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Nutter M. D.
Address 1118 Eutaw St Date signed 7/18/44

G19130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

G19130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 W. North Ave.
(c) Hospital or institution: 1540
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Ann Webb

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1853

8. AGE: Years 91 | Months 0 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Mt. Savage, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Zachariah Webb
13. Birthplace England

MOTHER
14. Maiden Name Ann Glear
15. Birthplace England

16 (a) Informant Mrs. Amelia Casey
(b) Address 2913 W. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland, Md.

18 (a) Funeral director Wm. J. Tickner & Sons,
(b) Address North & Pa. Aves.

19 (a) (Date of [illegible]) (b) Huntington Milburne, Md

JUL vs 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944, at 12-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1944 to July 17 1944, and that I last saw her alive on July 17 1944

Immediate cause of death: Arteriosclerotic Cardio vascular disease — Duration: 20 years
Due to: Senility
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Sullivan
Address 2911 Parkside Blvd Date signed 7-18-44

G19131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 W

Registered No. G19131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1848 Pennsylvania Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1848 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARCELLA BUTLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widow

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-1891

8. AGE: Years	Months	Days	If less than one day
53	4	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Smith
15. Birthplace Md.

16 (a) Informant Naomi Butler
(b) Address 1848 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location Md.

18 (a) Funeral director Mgr. H. Kelson
(b) Address 1303 Pennsylvania Ave Huntington Nottingham, Md.

19 (a) JUL 19 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1944, at 7:15 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed 7-17-44

VS 151

G19132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19132 Registered No.

1936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Francis Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Fankhanel / Fankhanel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine Schwemmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1859

8. AGE: Years 85 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry Fankhanel

13. Birthplace Germany

MOTHER 14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Mrs. Katherine Schwemmer

(b) Address 1211 Francis Ave Halethorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-44 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Dorsey, Md

18 (a) Funeral director Harry H. Witzke

(b) Address 4101 Edmondson Ave.

JUL 19 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry - Coroner thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.

Date signed 7/18/44

VS 151

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1943 Registered No. G19133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1321 Grinder Ave Court

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1808 Chesapeake Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Humphries

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race negro

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Sally Humphries

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 yrs. Months Days If less than one day hr. min.

9. Birthplace S.C. Spartanburg

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name "

13. Birthplace

MOTHER 14. Maiden Name "

15. Birthplace

16 (a) Informant wife. Sally

(b) Address 1321 Grinder Court

17 (a) Burial (b) Date thereof 7-19-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A.A. Co. — Md.

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 3221 N. Calvert St.

19 (a) July 19 1944 Huntington Williams Md.

(Date received by registrar) (Signature of registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947 at 2 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on July 15 1947.

Immediate cause of death	Duration
Terminal Bronchial pneumonia	12 hr.
Due to Hypertension	
Due to	
Other Conditions Hypertension Cardiac Insufficiency	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. J. Timmerman M.D.

Address 3716 Grinder Ave Date signed July 16 1947

G19134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19134 Registered No. 564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 567 Mosher St.
(If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Jones Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Aa	married

6 (b) Name of husband or wife James T. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-15

8. AGE: Years	Months	Days	If less than one day
28	10	5	— hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Nurse
11. Industry or business —

FATHER
12. Name James B. Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Lillie Bailey
15. Birthplace Md.

16 (a) Informant Mrs. James T. Smith
(b) Address 567 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-44 (month) (day) (year)
(c) Cemetery or crematory St. Lukes Cem.
Location Reisterstown, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JUL 19 1944 Registrar Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17- 1944, at 7 30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10-1944, to 7-17- 1944, and that I last saw h-- alive on 7-17 1944.

Immediate cause of death: Generalized Peritonitis — Duration

Due to

Due to

Other Conditions Post partum Shock

(Include pregnancy within 3 months of death)

Date of operation 7-11-44

Major findings of operation: Ruptured Appendix

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Jackson
Address Provident Hospital Date signed 7/22/44
M D

G19135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G19135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address 1817 Presstman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Presstman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Lula Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1878

8. AGE: Years 66 | Months 2 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Adam Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Deans
15. Birthplace Va

16 (a) Informant M. White
(b) Address 1817 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/44 (month) (day) (year)
(c) Cemetery or crematory Franklin Va
Location Va

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Presstman St

19 (a) Date received by Registrar JUL 19 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19XX, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 19XX, to July 18 19XX, and that I last saw h alive on July 16 19XX.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 week
Due to Cardio Vascular Disease	5 yrs
Due to Hypertension	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature William Frey M. D.
Address 428 Pennsylvania Ave. Date signed 7/19/44

G19136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47 C

G19136
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 7/6/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Dukeland Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM DOMER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1885

8. AGE: Years 58 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Catonsville, Md.
(Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Merchant Marine

FATHER
12. Name Conrad Domer
13. Birthplace Scotland

MOTHER
14. Maiden Name Sophia Silverburg
15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S.Matine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Roland Ave
18 (a) Funeral director G. Lee Adler
(b) Address 46 & York Rd Huntington Williams M.D.

JUL 19 1944
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH July 17, 1944, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1944 to July 17, 1944, and that I last saw h im alive on July 17, 1944

Immediate cause of death Lymphoblastoma, Hodgkin's type involving most of the thoracic & abdominal Xxxx organs — Duration Since Spring 1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/8/44-Left lumbar sympathetic injection

Major findings of operation: Thrombophlebitis left lower & upper leg & superficial veins.

Date of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. L. Alexander M.D.
Address Baltimore, Md. Date signed 7/18/44

MS-53994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Russell
3902 Groveland Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19137

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4011 Belvieu Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Belvieu Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Allen Wilson Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Aggie Mayer Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1867

8. AGE: Years 77 | Months --- | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Pattern Maker

11. Industry or business

FATHER: 12. Name Allen Nelson Wilson
13. Birthplace Baltimore, Maryland

MOTHER: 14. Maiden Name Clara Newman
15. Birthplace Baltimore, Maryland

16 (a) Informant George Allen Wilson Jr.
(b) Address 4006 Belvieu Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20, 44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Ellsworth Remaeod
(b) Address 3911 Liberty Heights Ave.

19 (a) (Date received by Local Registrar) Huntington Williams, M.D.
JUL 19 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1944, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1944, to 7/18 1944, and that I last saw him alive on 7/17 1944.

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).) (a) Arteriosclerosis
(b) Auricular fibrillation, Cardiac decompensation, Pulmonary hemorrhage
Due to moderate age
Due to
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 3902 Groveland Ave. Date signed 7/18/44

G19138

TN. 89016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PRINTED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Roles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 68 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Joshiah Roles
13. Birthplace Maryland

MOTHER: 14. Maiden Name Julia Robinson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy A Wilson

18 (a) Funeral director
(b) Address 1300 Brantley Ave

19 (a) (Registrar's signature) (b) Registrar

JUL 19 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 19YY, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16-44 19..., to 7-17-44 19..., and that I last saw him alive on 7-17-44 19...

Immediate cause of death	Duration
B. bronchopneumonia	?
Cerebral hemorrhage	?
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ax stone

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address Balt. City Hosp Date signed 7/18/44

G19139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19139
Registered No. —

Every item of information should be carefully supplied. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Calvin Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Calvin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Fell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1875

8. AGE: 68 Years | Months 10 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name ~~Friends~~ William H Busch

13. Birthplace Md

MOTHER 14. Maiden Name Mary C Busch

15. Birthplace ~~Here~~ Md

16 (a) Informant Mr. William H Busch BOND

(b) Address 5000 Catalpha Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Frederick Ave

18 (a) Funeral director William M Mareck

(b) Address 715 Light St

19 (a) 1944 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1944 at 1.30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio - vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Bayard B. McNally M.D.
Medical Examiner.

Date signed 7/20/44

G19140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 83 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7807 Elmhurst Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] Kapka [Lena]
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ernest Kapka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1906

8. AGE: Years	Months	Days	If less than one day
38 36	1	25	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Jangiwski
13. Birthplace Poland

MOTHER
14. Maiden Name Marcyna ?
15. Birthplace Poland

16 (a) Informant Hosfild Rundo
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Memorial Park
Location Balto. Co. Md.
18 (a) Funeral director Leonard Hunter
(b) Address 5015 Harford Road

JUL 19 1944 Registrar Christington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to July 18 1944, and that I last saw her alive on July 15 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Rheumatic Heart Disease	
Due to Sub-Acute Bacterial Endocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. L. Mengert Jr. M. D.
Address 322 E. University Pkwy Date signed 7/18/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G19141 CERTIFICATE OF DEATH 131a G19141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Colvert.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Kingsway Rd. #18 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas D. O'Grady.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Doris T.
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 3-18 1913

8. AGE: Years 31 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Furniture salesman.
11. Industry or business

FATHER 12. Name Patrick O'Grady.
13. Birthplace Ireland.

MOTHER 14. Maiden Name Delia Donlon.
15. Birthplace Ireland.

16 (a) Informant wife.
(b) Address same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto Md
18 (a) Funeral director Leonard J Finch
(b) Address 1305 Wanford Rd
19 (a) (b) Registrar
(Date received by registrar)

JUL 19 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18-44 19 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1944 to 7-18 1944 and that I last saw him alive on 7-18- 1944

Immediate cause of death: Cardio-respir. failure due cerebral edema — Duration 2 d.
Due to: ↓ intracranial pressure. —
Due to: Malign. hypertension due to chronic — 2 yr.
Other Conditions: glomerulonephritis — 4 y.

(Include pregnancy within 3 months of death)
Date of operation: 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Kilfoyle M. D.
Address Union Mem. Hosp. Date signed 7-18-44

G19142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1319 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 10
(e) Length of stay in Baltimore (yrs., mos., or days): 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 E. Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha B. Sayles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles Sayles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months 10 | Days — | If less than one day hr. min.

9. Birthplace Reisterstown Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Clark
15. Birthplace Maryland

16 (a) Informant Elizabeth Redman
(b) Address 1319 E. Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)
(c) Cemetery or crematory Laurel Mem
Location Baltimore Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 142 Jefferson St

19 JUL 20 1944 [illegible] Baltimore, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1943 to July 18 1943, and that I last saw h[illegible] alive on July 17 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days
Due to: Hypertensive Cardio Vascular Disease — 7
Due to:
Other Conditions: Arteriosclerosis — 7.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 222 N. Carrollton [illegible]
July 19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G19143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 E Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 E Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Parker

3 (b) If veteran, name war

3 (c) Social Security Account No. 215059560

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1911

8. AGE: Years	Months	Days	If less than one day
32 33	10	-	hr. min.

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name John Parker Sr.
13. Birthplace Richmond Va

MOTHER — 14. Maiden Name Lula Promise
15. Birthplace Richmond Va

16 (a) Informant Lula Parker Mother
(b) Address 1808 E Madison St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7 21 44 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem
Location Richmond Va

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 JUL 20 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to July 18 1944, and that I last saw him alive on July 17 1944

Immediate cause of death: Chronic Interstitial Nephritis — Duration 6 mo

Due to:

Due to:

Other Conditions Arterio sclerosis Hypertension 6 mo
and Mitral Insufficiency
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J Young M.D.

Address 1424 E Madison St Date signed 7/19/44

G19144
IL - 88154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13½

G19144
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Amrhein

3 (b) If veteran, name war
3 (c) Social Security Account No. 214-03-4303

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1905

8. AGE: Years	Months	Days	If less than one day
38	8	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Bernard Amrhein
13. Birthplace Md.
14. Maiden Name Julia Groutkowski
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
19 (a) Date received JUL 20 1944 (b) Registrar Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-44 19.., at 1¼ A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 19 44, to 7-17-44 19.., and that I last saw h.m alive on 7-16 19 44.

Immediate cause of death Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Peery Jr. M. D.
Address City Hosp., Balt. Date signed 7-17-44

G19145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Ellicott Dr (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Feeney

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Minnie Feeney
6 (c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.): Aug 1866
8. AGE: Years 78 | Months | Days | If less than one day: hr. min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name (Unknown) Feeney
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant: Edward L. Feeney
(b) Address: 619 S. Decker St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/21/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~: St. Pauls Reformed
Location

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st

JUL 20 1944
(Date rec'd by registrar) Huntington Williams, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1944, at 5:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. for Medical Examiner.
Date signed July 19, 1944

G19146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

G19146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley B. Maccubbin, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 189[illegible]

8. AGE: Years 59 | Months 8 | Days 22 | If less than one day: hr. min.

9. Birthplace: Norfolk, Va. (Town, county, and state)
10. Usual Occupation: Delivery man
11. Industry or business: Home Pie Co.

FATHER
12. Name: George B. Maccubbin
13. Birthplace: Norfolk, Va.

MOTHER
14. Maiden Name: Mary E. Barnes
15. Birthplace: Norfolk Va.

16 (a) Informant: Mrs. Irene Webster
(b) Address: 14 4th ave. Edmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/44 (month, day, year)
(c) Cemetery or crematory: Moreland Park
Location: Balto. Co., Maryland

18 (a) Funeral director: William Cox Inc
(b) Address: 217 E Read St

19 JUL 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 10:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed July 19, 1944

G19147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19147 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Matthew st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Matthew st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Denbow

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name ~~of husband or~~ wife Elizabeth Denbow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26th 1855

8. AGE: Years	Months	Days	If less than one day
89	2	23	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Denbow
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Catherine Stridal
15. Birthplace Harford Co. Md.

16 (a) Informant Samuel T. Denbow
(b) Address 2702 Matthew st

17 (a) Burial (b) Date thereof 7-22-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Zion
Location Harford Co. Md.
18 (a) Funeral director William Cox Sons
(b) Address 217 St. Paul st.
19 (a) (b) Registered

JUL 20 1944
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1942 to July 19 1944; and that I last saw him alive on July 15 1944

Immediate cause of death: Arterio Sclerosis
Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M. D.
Address 4436 Reisterstown Rd Date signed July 19 1944

G19148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G19148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARRON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Richmond Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 512 Richmond Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A Bruce Thomas

3 (b) If veteran, name war W
3 (c) Social Security Account No. 218-03-1345

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Della K
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1887

8. AGE: Years 56 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace MD (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER 12. Name Joseph Thomas
13. Birthplace MD

MOTHER 14. Maiden Name Mary Mears
15. Birthplace MD

16 (a) Informant A Bruce Thomas Jr
(b) Address 322 Redmon St

17. Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto Co MD

18 (a) Funeral director Phillips & Doe
(b) Address 1210 Park Ave

19 (a) JUL 20 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1944, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 7/16 1944; and that I last saw h[illegible] alive on 7/16 1944.

Immediate cause of death: Arteriosclerosis Heart Disease — Duration 1 hour

Due to

Due to

Other Conditions Hypertension Blood Pressure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: X

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Stearn MD
Address 7901 Harrison Ave Date signed 7/19/44

G19149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19149 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 (Rigge)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Rigge Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Burns Doyle

3 (b) If veteran, name war | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife John J. Doyle | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-24-1861

8. AGE: Years 82 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER — 12. Name Peter Burns
13. Birthplace Balto, Md

MOTHER — 14. Maiden Name ~~Margaret Burns~~
15. Birthplace ~~Balto~~ Md.

16 (a) Informant Margaret Norwood
(b) Address 2310 Riggs Ave.

17 (a) (Burial, cremation, or removal) (b) Date of [illegible] 7/20/44 (month) (day) (year)
(c) Cemetery or crematory Mew Cathedral
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) JUL 20 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1944 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to July 17 1944 and that I last saw h[illegible] alive on July 17 1944

Immediate cause of death Acute hemorrhage from right axillary artery — Duration 9 hours
Due to Carcinoma of right Breast & right axilla — 5 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. J. Sullivan
Address 2911 Harrison Blvd Date signed 7-18-44 M. D.

a-3650 +

G19150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 13 ✓

G19150 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give name)
(d) Street No. 247 St Helena Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myron Frey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-42

8. AGE: Years	Months	Days	If less than one day
1	2 9	16	hr. min.

9. Birthplace D.C (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Myron Frey.
13. Birthplace Md

MOTHER
14. Maiden Name Blanche Fleming
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22. (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Fountain Green Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) JUL 20 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 19 1944 and that I last saw him alive on July 19 1944

Immediate cause of death	Duration
Tuberculous meningitis	2 wks
Due to miliary tuberculosis	?
Due to pulmonary tbc	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Joel Koviz M. D.
Address Johns Hopkins Hosp Date signed 7-19-44

G19151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 N

Registered No. G19151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts.
(c) Hospital or institution: West Balt Gen'l Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11.
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD B. FERGUSON.

3 (b) If veteran, name war: None.

3 (c) Social Security Account No. 216-03-5548

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Maude E. Ferguson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23-1882.

8. AGE: Years 61 Months 10 Days 25 If less than one day hr. min.

9. Birthplace Winchester - Va.
(Town, county, and state)

10. Usual Occupation Plasterer.

11. Industry or business

FATHER
12. Name James Ferguson.
13. Birthplace Winchester - Va.

MOTHER
14. Maiden Name Emma Rosenberger.
15. Birthplace Va.

16 (a) Informant Mrs. Maude E. Ferguson
(b) Address 1127 N. Monroe St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron Cem.
Location Winchester Va.

18 (a) Funeral director Charles J. Schuyler
(b) Address 505 N. Monroe St.

JUL 20 1944 (b) Huntington Williams Mgr.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18/44 19 at 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1944 to 7/18 1944 and that I last saw h.im alive on 7/18 19 44.

Immediate cause of death: Cardiac Failure — Duration

Due to

Due to Hypertensive CVD

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. N. Friedman

Address West Balt. Gen'l Hosp. Date signed 7/18/44 M.D.

G19152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No. G19152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4248 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4248 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Gladstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Isidor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-1879

8. AGE: Years 65 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Odessa - Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Leiser Teper

13. Birthplace Russia

MOTHER 14. Maiden Name Chave Anna

15. Birthplace Russia

16 (a) Informant Dr. W. W. Grossman

(b) Address 4248 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Jacob Heine Inc

18 (a) Funeral director E. Balto St.

(b) [illegible]

19 (a) JUL 20 1944 Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1944 to July 19 1944 and that I last saw h[illegible] alive on July 19 1944.

Immediate cause of death	Duration
Hypertensive C V Disease	Few yrs
Due to Cerebral Hemmorrhage	2 days
Due to Coma & Convulsion	3 days
Other Conditions Pulmonary Edema	3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex A Weinstock M. D.

Address 4103 Pk Heights Ave Date signed 7/19/44

VS 180

G19153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

G19153 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334 Pontiac Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn 25 Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Pontiac Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Severn C. Baker
3 (b) If veteran, name war Spa.
3 (c) Social Security Account No. 215-07-9618
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Annie C. Baker
6 (c) If alive, give age No years
7. Birth date of deceased (mo., day, yr.) Nov. 9-1882
8. AGE: Years 61-62 Months 8 Days 9 If less than one day hr. min.
9. Birthplace Balto County, (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business U.S. Industrial Alcohol Co.

MOTHER / FATHER
12. Name Unknown
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr John A Baker
(b) Address 1334 Pontiac Ave (25)
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Ritchie Highway Md
18 (a) Funeral director Mitchell Schilling
(b) Address 2914 S. Hanover St.
(a) (b) Washington Ave Millersville, Md.
JUL 20 1944

MEDICAL CERTIFICATION

19. DATE OF DEATH July 18 1944 at 4.35 PM
20. I certify that death occurred on the date above stated; that I attended deceased from June 8 1944, to July 18 1944, and that I last saw him alive on 7-14 1944.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Hypertensive Cardiovascular	
Due to disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel Rubin M. D.
Address 20 3 Baltimore Date signed

VS 150

G19154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94W

G19154
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Wiggins

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-9910

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Col.	married

6 (b) Name of ~~husband~~ or wife Annie Siler Wiggins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Siler City, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Wiggins
13. Birthplace Virginia

MOTHER 14. Maiden Name Pauline ?
15. Birthplace Virginia

16 (a) Informant Jessie James Siler
(b) Address 1425 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20 (month) (day) 1944 (year)
(c) Cemetery or crematory Suffolk
Location Virginia

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 15 JUL 20 1944

MEDICAL CERTIFICATION A.R.

20. DATE OF DEATH July 18 1944, at 5:45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed July 19, 1944

G19155

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19155 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1382 Woodyear St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1382 Woodyear St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Goodman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1916

8. AGE: Years 28 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Elizabeth, N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raphael Goodman
13. Birthplace Elizabeth, N.C.

MOTHER
14. Maiden Name Florence Brafton
15. Birthplace Middlesex Co. Va.

16 (a) Informant Mrs. Loretta Brantley
(b) Address 1410 Presengurst

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr Katie R. William
(b) Address 322 N Schroeder St

19 (a) Date received by Registrar JUL 20 1944 (b)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1944, at 2.05 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner. 7/19/44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19156

G19156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190 Registered No. G19156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital Dept 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Carol Ann Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1943

8. AGE: Years	Months	Days	If less than one day
1	16	6	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Smith
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Va.

16 (a) Informant Mrs. Carol Sherman
(b) Address 617 W. Franklin St

17 (a) Burial (b) Date thereof 7-24-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Fotobahy Interred
(b) Address 217 W. Lexington St

19 (a) Thurston Funeral Home (b) Williams JUL 20 1944
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhoea of Infancy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature Walter J. Sobriecki M.D.
Medical Examiner.
Date signed 7/19/44

G19157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 C

Registered No. G19157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 Wilmot Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Wilmot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Smith

3 (b) If veteran, name war: Spanish Amer. War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Catherine Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21-1867

8. AGE: Years 76 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Smith
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Anna Schneider
(b) Address 3105 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22-44 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location E. Donnell St

18 (a) Funeral director John A. Miller
(b) Address 2034 Jefferson St

19 (a) JUL 20 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 - 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1- 1944 to July 15 1944 and that I last saw h. alive on July 15 1944

Immediate cause of death: Coronary Thrombosis. Cardiac decompensation.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Grantham M. D.
Address 3139 E. Baltimore St. Date signed 7-19-44

G19158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1139 Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Gross

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1913

8. AGE: Years	Months	Days	If less than one day
31	4	10	hr. min.

9. Birthplace S. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Daniel Gross
(b) Address 1139 Lexington Street

17 (a) Burial (b) Date thereof 7/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Burnett
(b) Address 108 W Montgomery St Huntingtown Williams, Md.

19 (a) JUL 20 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 1944; at 12-30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Scirrhous Carcinoma, Breast with Metastases

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 7-20-44

G19159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G19159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Re-A-Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 6401 Pinehurst Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Thayer O'Connor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1894

8. AGE: Years 50 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace: Marietta, Pennsylvania (Town, county, and state)

10. Usual Occupation: Vice Pres.

11. Industry or business: Pa. Water & Power Cp.

FATHER
12. Name: Arthur P. O'Connor
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Susan May
15. Birthplace: Unknown

16 (a) Informant: Mrs. Mary T. O'Connor
(b) Address: 6401 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1944 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves. Balto. Md

19 (Signature of local registrar) JUL 20 1944 Thurlington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ——— at ——— M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? —
(d) Means of injury

23. Signature: Charles F. Sutherland M.D. Medical Examiner.
Date signed 7/20/44

G19160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19160 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Sparrows Point R.F.D. #10.
(If outside city or town limits, write RURAL and give town)
(d) Street No. None (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna [illegible] Todd

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife J. Ridgely Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1904

8. AGE: Years	Months	Days	If less than one day
40	4	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George E. Brill
13. Birthplace W. Va.

MOTHER
14. Maiden Name Marie Breuller
15. Birthplace Maryland

16 (a) Informant Hospital Adm. Slip.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Todd Inheritance
Location North Point Road Balto. Co.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 Date received by JUL 20 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19 1944, at 4:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1944 to 7/19 1944, and that I last saw her alive on 7/19 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Metastatic Lymphosarcoma	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hospital Date signed 7/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESERVED FOR BINDING

G19161
JL - 88965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 1600

Registered No. G19161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Gold St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Tyler.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1944

8. AGE: Years | Months | Days | If less than one day: 20 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carroll Watkins
13. Birthplace Md.

MOTHER
14. Maiden Name Millicent Tyler
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave. at 9 P.M.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-18-44 (month) (day) (year)
(c) ~~Cemetery or~~ crematory 4940 Eastern Ave
Location Balto City Hosp.

18 (a) Funeral director
(b) Address

(Date received by local registrar) JUL 20 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 1944 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1944 to 7-14 1944, and that I last saw h.e.M alive on 7-13- 1944.

Immediate cause of death: INTRA CRANIAL Hemorrhage — Duration: 20 hr.
Due to BIRTH INJURY
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Kerr Jr. M.D. M. D.
Address Balto City Hosp. Date signed 7/17/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ACCOUNT RESERVED FOR BINDING

G19162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 183

G19162

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Grantley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Holden

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-3767

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Gertrude Costs Holden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1885

8. AGE: Years	Months	Days	If less than one day
58	7	25	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Asst. Supt.
11. Industry or business Standard Oil Co.

FATHER
12. Name Edward H. Holden
13. Birthplace England

MOTHER
14. Maiden Name Mary Enid Thrift
15. Birthplace England

16 (a) Informant Mrs. Gertrude Holden
(b) Address 617 Grantley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-22-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry H. Witte
(b) Address 4101 Edmondson Ave.

19 (a) JUL 20 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944, at 10 40 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained. (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 18 1944 at after 8 P 2515 M.
(b) Where did injury occur? Standard Square Pier
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? No
(d) Means of injury Drowning

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed July 19, 1944

VS 151

G19163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 161c

Registered No. G19163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7315½ Windsor Mill Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Boy Detzel

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. .....

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 9, 1944

8. AGE: Years ..... Months ..... Days 10 da | If less than one day ..... hr. ..... min.

9. Birthplace W. B. D. H. (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Charles Henry Detzel
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Mary McDonaldson
15. Birthplace Harrisonburg, Va.

16 (a) Informant .....
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (Date rec'd by registrar) JUL 20 1944

UNIVERSITY MEDICAL SCHOOL JUL 20 1944
Commissioner of Health
Huntington and Williamsway Mail

VS 150

2011

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1944, at 2 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944, to July 19 1944, and that I last saw him alive on July 19 1944.

Immediate cause of death ..... Duration
Anemia
Due to Leukemia Leukemia
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Carter Baldwin M. D.
Address West Balt. General Hosp. Date signed 7-19-44

G19164 G19164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Harwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) abt 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Harwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Clara Beall Benninghaus

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None
4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) about 1859
8. AGE: Years: about 85 Months: — Days: — If less than one day: hr. min.
9. Birthplace: Ohio (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Herman Benninghaus
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise Miles
15. Birthplace: Ohio

16 (a) Informant: Mrs. Irene Thompson (Friend)
(b) Address: Clarington - Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-44 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Balto, Md.

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) JUL 20 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944 at 12:05 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1943 to July 18 1944, and that I last saw her alive on July 18 1944.

Immediate cause of death: Coronary occlusion — Duration 3 days.
Due to: Arteriosclerotic heart disease — Duration 15 yrs. abt.
Due to: Hypertension — Duration 15 yrs. abt.

Other Conditions: None
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. E. Chatfield, M. D.
Address 610 York Rd. Date signed 7-20-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19165

Registered No. G19165

G19165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Walter Watson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-9350

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mary C. Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1886

8. AGE: Years 58 | Months - | Days 28 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation waiter

11. Industry or business —

FATHER
12. Name
13. Birthplace N. C.

MOTHER
14. Maiden Name Esther Watson
15. Birthplace N. C.

16 (a) Informant Mary C. Watson, wife
(b) Address 715 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 JUL 20 1944 (b) registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18- 1944, at 6.5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1- 1944 to 7-18 1944 and that I last saw him alive on 7-18-1944.

Immediate cause of death
Cardiac + Respiratory failure
Due to Cerebral Hemorrhage 2 wks
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Harmon M. D.
Address 2340 Madison Ave. Date signed 7-20-44

Louis E. Harmon

G19166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1048

G19166
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Eye Ear Throat Charity Hospital
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Baltimore Eye Ear Throat Charity Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore Md (Curtis Bay)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Valve Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack, Charles (Charles W. Jack)
3 (b) If veteran, name war
3 (c) Social Security Account No. 235-16-3758

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Golda Jack
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 2, 1899
8. AGE: Years 44 | Months 9 | Days 18 | If less than one day hr. min.
9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Ship yard

FATHER
12. Name Jack, Clarence
13. Birthplace West Virginia

MOTHER
14. Maiden Name Williams, Anna
15. Birthplace West Virginia

16 (a) Informant Hospital Record Corpse and return
(b) Address 905 Valve St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Ellys for Masonic Cem
Location Fayetteville W. Va.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Key Hwy

20 1944 (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to July 20 1944 and that I last saw him alive on July 20 1944.

Immediate cause of death	Duration
Osteomyelitis frontal sinus	6 wks.
Due to Frontal Sinusitis	
Due to	
Other conditions Frontal Lobe Brain Abscess	

(Include pregnancy within 3 months of death)

Date of operation 7/13/44
Major findings of operation Osteo of frontal sinus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel L. Sut M.D.
Address 1820 Eutaw Pl. Date signed 7/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G19167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19167
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline and Oliver St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 Eaton St (Eaton) (Give usual place of location)
(e) Citizen of foreign country? Eaton (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Ann Glorioso

3 (b) If veteran, name war | 3. (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15-1944

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace St. Joseph's Hospital Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Angelo Glorioso
13. Birthplace Trinidad Colorado

MOTHER
14. Maiden Name Philomena Imbraguglio
15. Birthplace Trinidad Colorado

16 (a) Informant Angelo Glorioso
(b) Address 234 Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21. 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location City

18 (a) Funeral director Mrs. John N. Teufel & Son
(b) Address 801 W Fayette St

July 20 1944 Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 8 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 19 44, to 7/19 19 44, and that I last saw h. alive on 7/19 1944.

Immediate cause of death: Inter cranial Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Bellina M. D.
Address St. Joseph's Hosp. Date signed 7/20/44

32547 G19168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G19168
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The date of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5741 Jonquil Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Sober

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mollye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1891

8. AGE: Years	Months	Days	If less than one day
53	2	9	hr. min.

9. Birthplace Poland (Town, county and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER 12. Name Jacques Sober
13. Birthplace Poland

MOTHER 14. Maiden Name Jennie Sheuter
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location German Hill Road

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W North ave

19 (a) JUL 20 1944 (b) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944 at 8.12 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1944 to July 19 1944 and that I last saw him alive on July 19 1944

Immediate cause of death	Duration
Carcinoma sigmoid colon - perforation	
Due to Wound of peritoneum.	
Intestinal obstruction	
Due to Cerebral emboli?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 5 1944
Major findings of operation: Carcinoma sigmoid colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Downs
Address Johns Hopkins Hosp Date signed 7/19/44

G19169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G19169
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied as fully as possible. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and fully.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1904 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha M. Hebron Mitchelbrune

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1881

8. AGE: Years	Months	Days	If less than one day
63	2	4	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Franklin P. Weeks
13. Birthplace Virginia

MOTHER
14. Maiden Name Caroline Granblett
15. Birthplace Virginia

16 (a) Informant Miss Ella Weeks
(b) Address C/o Baltimore City Hospitals

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)
(c) Cemetery or crematory Manassas
Location Manassas, Virginia

18 (a) Funeral director George W. Schwartz
(b) Address 2101 Frederick Avenue

19 (a) [illegible] (b) [illegible]

JUL 20 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry-Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury

23. Signature Peter J. Skibinski M.D.
Medical Examiner.
Date signed 7/19/44

G19170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a G19170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 134 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Corrected Joseph F. Berry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1879

8. AGE: Years 64 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Tavern Keeper

11. Industry or business "

FATHER
12. Name Frank Berry
13. Birthplace Bohemia

MOTHER
14. Maiden Name Josephine Petrik
15. Birthplace Bohemia

16 (a) Informant Joseph F. Berry, Jr
(b) Address 1529 N. Patterson Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Enoch & Son
Address 700 N. Chester St

19 (a) JUL 20 1944 (Date rec'd by Local Registrar) (b) Huntington, Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-44 19 , at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1- 1944 to 7-17 1944, and that I last saw him alive on 7-17 1944

	Duration
Immediate cause of death Congestive heart failure	
Due to Uremia	
Due to Chronic Nephritis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Ranz M. D.
Address Union Hosp Date signed 7-17-

G19171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

G19171
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5009 Beaufort Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 07
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Beaufort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E Sullivan

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1903

8. AGE: Years 44 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Edward Yingling
13. Birthplace Pa
14. Maiden Name Annie Little
15. Birthplace Md

16 (a) Informant Harry Sullivan
(b) Address 5204 Beaufort Ave

17 Burial (Burial, cremation, or removal) (b) Date thereof 7/22/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Thos F Kelly & Son
(b) Address 1217 Huntington Ave, Baltimore, Md

JUL 21 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944 at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1944 to July 18 1944 and that I last saw h alive on July 18 1944

Immediate cause of death Apoplexy — Duration 5 hrs.
Due to Hypertension — 4 yrs
Due to Chronic Nephritis — 4 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Hall Lane M. D.
Address 1 E Randall St Date signed 7/19/44

G19172 BRAUER X ✓ G19172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution West Balt. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 96
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Belair.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace C. Brauer.

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE
4. Sex Female
5. Color or race White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married
6 (b) Name of husband ~~or wife~~ Albert Brauer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 18th 1877
8. AGE: Years 67 Months 4 Days 1 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name (Un Known) Brown
13. Birthplace "

MOTHER
14. Maiden Name Charlotte Courtney
15. Birthplace Va.

16 (a) Informant Albert C. Brauer
(b) Address 829 N. Augusta Ave
17 (a) Burial (b) Date thereof 7/22/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St
JUL 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19 1944 at 9.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1944 to 7/19 1944, and that I last saw h.e alive on 1944.

Immediate cause of death Cardiac Failure — Duration 12 Days.
Due to Cirrhosis
Due to
Other Conditions Pulmonary Edema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinoma of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl W. Baldeman M. D.
Address West Balt. General Hosp. Date signed 7-19-44

G19173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G19173 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8. Southgates Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days) the

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 Kirk ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas McWilliams

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Mary J. McWilliams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 - 1872

8. AGE: Years	Months	Days	If less than one day
72	1	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas McWilliams
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann. (unknown)
15. Birthplace Ireland

16 (a) Informant Mary J. McWilliams.
(b) Address 2550 Kirk ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 7/22/44 (month) (day) (year)
(c) Cemetery or Crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

JUL 21 1944 (Date received by Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION 35

20. DATE OF DEATH July 19 1944, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1944 to July 19 1944, and that I last saw h[illegible] alive on July 18 1944.

Immediate cause of death	Duration
Broncho Pneumonia	2 d.
Due to Cerebral Hemorrhage	15 d.
Due to Arterio Sclerosis Hypertension	15 d.
Other Conditions Diabetes Mellitus Hypertension Nephritis	15 d.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature I F A Stevens
Address 2878 Hartford Av. Date signed July 20 44

G19174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146c

Registered No. G19174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Christian St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Warman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 11, 1912

8. AGE: Years	Months	Days	If less than one day
31	10	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER: 12. Name Louis Baker
13. Birthplace Russia

MOTHER: 14. Maiden Name Rose Potlock
15. Birthplace Russia

16 (a) Informant Frank Weiman
(b) Address 2103 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Brps
(b) Address 1124 1126 W North Ave

19 (a) Date rec'd by registrar JUL 21 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20/44 19 , at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 19 44 to 7/20 19 44 and that I last saw h[illegible] alive on 7/20 19 44

Immediate cause of death: Post-partum Hemorrhage Shock — Duration

Due to Uterine atonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond B. Goldberg M. D.
Address Sinai Hosp. Date signed 7/20/44

G19175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G19175 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 Elsinor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Elsinor Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Emma Caroline Nutter

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 218-12-6437

4. Sex Female 5. Color or race White

6 (a) Single, married, widowed, or divorced. widow

(b) Name of husband or wife Herman Nutter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11 1883

8. AGE: Years 60 Months 8 Days 9 If less than one day hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name August Oeckert
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Sieke
15. Birthplace Germany

16 (a) Informant Mrs Eleanor J Fischbach
(b) Address 2403 Elsinor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

JUL 21 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944, at 11 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1944 to July 20 1944, and that I last saw her alive on July 15 1944.

Immediate cause of death Carcinoma of Pancreas — Duration 1 yr.
Due to
Due to
Other Conditions Metastases

(Include pregnancy within 3 months of death)

Major findings:
Of operations Laparotomy Carcinoma of Pancreas.
Of autopsy No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua H. Armacost M. D.
Address 6419 Windsor Mill Rd signed
Baltimore-7 9/20/44

G19176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G19176 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 N Appleton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL or give town)
(d) Street No. 311 N. Appleton St (Rural giving location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Cottman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Ebenezer Cottman

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Francis Byrd

15. Birthplace Md

16 (a) Informant Irine R Cornish Daughter

(b) Address Fredericksburg, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Brantley St

19 JUL 21 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944 at 7:16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944 to July 18 1944.
and that I last saw h alive on 19

Immediate cause of death Arteriosclerotic Cardiac Collapse

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Hovey

Address 754 Eager St Date signed July 20 1944

G19177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19177
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-
(c) Hospital or institution: University Hospital - D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits write RURAL and give town)
(d) Street No. 10 N Rolling Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew D' O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Theresa M O'Connor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14/1882

8. AGE: Years 62 Months 6 Days 5 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Painter

11. Industry or business

FATHER
12. Name Michael E O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Dorothy Mary Adams
15. Birthplace Baltimore Md.

16 (a) Informant Theresa M. O'Connor
(b) Address 10 N. Rolling Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23/1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Harry K Thomas
(b) Address 4202 Ridgewood Ave

19 JUL 21 1944 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles J Sullivan M.D.
Medical Examiner.
Date signed 7/20/44

G19178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G19178 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Winchester st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Winchester st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARCELLA P. MAXWELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Stanley P.

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 2-1876

8. AGE: Years 68 | Months 21 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name James Baker
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace Md

16 (a) Informant Stanley P Maxwell
(b) Address 2803 Winchester st

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-22-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Balto Md

18 (a) Funeral director Leonard Hyatt
(b) Address 4130 N Monument

19. JUL 21 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944 at 9.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1944 to July 19 1944, and that I last saw h alive on July 18 1944

Immediate cause of death Cerebral Thrombosis — Duration 15 days

Due to Pneumonia

Due to General Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

If autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? (Specify type of place)
(e) Means of injury ✓

23. Signature Helen A. Thatcher M.D.

Address 2219 Eutaw Place Date signed 7/29/44

M. D. B. 1208-B

G19179

G19179 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1482

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Boyd St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Grace Thomas

(a) Residence: No. 930 Boyd St. 18-3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Mar.

5a. If married, widowed, or divorced WIFE of Horace Thomas

6. DATE OF BIRTH (month, day, year) May 30, 1918

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	1	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation.

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Richard Thomas

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Bertina White

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Richard Thomas
(Address) 930 Boyd St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Auburn Date July 21, 1944

19. UNDERTAKER Mr Peter R Williams
(Address) 322 N Schroeder St

20. FILED JUL 21 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 18, 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1944 to July 17, 1944

I last saw her alive on July 17, 1944. Death is said to have occurred on the date stated above, at 9:45 P.m..

The principal cause of death and related causes of importance were as follows:

	Date of onset
Ca Uteri	5½ Mos

Other contributory causes of importance:

Burnt Arm	1944

Name of operation ... Date of ...

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Mel V. Bando M. D.

(Address) 2445 W Hill Ave., Balto., Md.

v. s. 9

G19180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

G19180
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 W. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City~~ or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 15 W Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel Richardson Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 - 1850

8. AGE: Years	Months	Days	If less than one day
~~94~~ 93	9	3	hr. min.

9. Birthplace Natchez - Miss -
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name William Cannon
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane E Shipp
15. Birthplace Maryland

16 (a) Informant Miss Maretta Cannon
(b) Address 15 W. Lanvale St

17 (a) Burial (b) Date thereof July 22 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Henry N Jenkins Son
(b) Address McCulloh & Orchard Sts

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

JUL 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944, at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1930 to July 20 1944 and that I last saw h alive on 7/20 1944.

Immediate cause of death Coronary Thrombosis. | Duration 2 hrs
Due to Myocarditis. Arterio-Sclerosis | Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W H Moody M.D.
Address 1402 Park Ave Date signed 7/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G19181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. West St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Walker

3 (b) If veteran, name war

3 (c) Social Security Account No. 249-14-0265

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1916

8. AGE: Years	Months	Days	If less than one day
28	-	16	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Walker
13. Birthplace S. C.

MOTHER
14. Maiden Name Fitzner Tindle
15. Birthplace S. C.

16 (a) Informant Marie Walker
(b) Address 512 W West Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 23 '44 (month) (day) (year)
(c) Cemetery or crematory
Location Sumter South Carolina

18 (a) Funeral director Isaiah R Brown Son
(b) Address 1086 Montgomery St

19 (a) JUL 21 1944 (Date rec'd by reg.) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 10:05 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns 2nd & 3rd degree entire body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 19 1944 M.
(b) Where did injury occur? 59 S. Arlington St
(c) Did injury occur at home, on farm, industrial place, in public place? Above address While at work? No
(d) Means of injury Burns caught on fire

23. Signature H. L. Wolfenden M.D. Medical Examiner.
Date signed July 19, 1944

G19182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G19182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 W. Montgomery
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Sgnt.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1944

8. AGE: Years	Months	Days	If less than one day
	3	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Spencer White
13. Birthplace Virginia

MOTHER 14. Maiden Name Letha Dorsey
15. Birthplace Maryland

16 (a) Informant Spencer White
(b) Address 510 W. Montgomery St.

17 (a) Burial (b) Date thereof July 21 44
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A.Co. Md.

18 (a) Funeral director Gerard L Bowman Son
(b) Address 1058 W Mount Royal Place

19 JUL 21 1944 (Huntington Williams, M.D.)
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1944 to 7/18 1944, and that I last saw h.i.m. alive on 7/18 1944.

Immediate cause of death	Duration
Peripheral vascular collapse	2 hours
Due to Waterhouse-Friderichsen syndrome ??	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Marbarger M. D.
Address University Hospital Date signed 7/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RIGHTS RESERVED FOR BINDING

G19183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19183 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BROWN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 653 Lee St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation STEVEDORE
11. Industry or business

FATHER
12. Name James Jones
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace N. C.

16 (a) Informant Mary Pattlow
(b) Address 658 Lee St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23. 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md.

18 (a) Funeral director Josiah P. Brown Son
(b) Address 1081 W. Montgomery Street

19 (a) (Registrar) Huntington Williams, M.D.
(b) Date received JUL 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1944, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1944, to July 19, 1944, and that I last saw him alive on July 19, 1944.

Immediate cause of death	Duration
CEREBRO-VASCULAR ACCIDENT	2 days
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	unknown years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin Hoffman
Address University Hospital Date signed 7/26/44

HINIG MAN

G19184 — Baltimore City [redacted] DEPARTMENT OF HEALTH — G19184

CERTIFICATE OF DEATH 83a

Reg. Dist. No. _____

1. PLACE OF DEATH:
County: Balto
City or town: Balto
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred: 703 S. Fagley St
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: 703 S. Fagley
(If rural, give LOCATION)
2.(c) If veteran, name war: —

3. (a) FULL NAME: Mary Elizabeth Kafer
3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Adam Kafer — 6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 21, 1890

8. AGE: Years	Months	Days	If less than one day
53	11	17	11 hrs. 30 min.

9. Birthplace: Balto, Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Conrad Wagner
13. Birthplace: Germany

MOTHER
14. Maiden name: Katherine Jubb
15. Birthplace: Balto, Md

16. Informant: Mr Adam Kafer
Address: 703 S. Fagley

17. Burial — Date thereof: 7/22/44
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave.

18. Funeral director: Clarence F. Hoffmann
Address: 1639 N. Broadway

19. JUL 21 1944 Huntington Williams, Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1944 at 11.30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from _____ 19__ to _____ 19__ and that I last saw h[illegible] alive on July 18 1944

Immediate cause of death: Cerebral Hemorrhage — DURATION: 10 days
Due to: Cerebral Arteriosclerosis & Hypertension — 3 yrs
Due to: —
Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op. —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: J. Howard Burns M.D.
M. D. or other
Address: 69 Dundalk Ave. — Date signed: July 19 1944.

G19185 ✓ G19185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Every item of information should be carefully supplied. The correct answers especially important. Physicians: please write plainly, WITH UNFADING INK. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins - D.on 6b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. Bethel St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME John Nicholson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1894

8. AGE: Years 49 | Months 6 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Viola Jones
(b) Address 1434 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
(d) Funeral director Thos O. Wilson
(e) Address 1000 Pennsylvania Ave

19 (a) 7/21/1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - thereof and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis
Due to Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles P. Sulmi M.D.
Medical Examiner.
Date signed 7/20/44

VS 151

G19186 BALTIMORE CITY HEALTH DEPARTMENT G19186
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Lemmon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PERCY Yedon JONES

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-1066

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12. 1909

8. AGE: Years 35 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Concord Depot Va (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Shipyard

FATHER 12. Name Robt H. Jones

13. Birthplace Gladys Va

MOTHER 14. Maiden Name Cora Haymaker

15. Birthplace Bodytop Va

16 (a) Informant Robt H Jones

(b) Address 427 E Getting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/44 (month) (day) (year)

(c) Cemetery or crematory

Location Lynchburg Va

18 (a) Funeral director Thos J Kenny

(b) Address Hollins & Gilmor

JUL 21 1944

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944, at 3 40 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D. Asst Medical Examiner.

Date signed 7-21-44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G19187 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3531 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3531 Keswick Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Leonard Palmer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marge Anna Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12-1867

8. AGE: Years 76 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stone Mason

11. Industry or business Retired

FATHER 12. Name John Palmer
13. Birthplace Baltimore Co. Md

MOTHER 14. Maiden Name Susan Pell
15. Birthplace Maryland

16 (a) Informant Mrs. Margie A. Palmer
(b) Address 3531 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22-1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location Fruitlands, Baltimore Co. Md

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

JUL 21 1944 (Date registered) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 7.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 42 to July 19 1944, and that I last saw him alive on July 19 1944.

Immediate cause of death	Duration
Pulmonary Edema	2 days
Due to Congestive Heart Failure	several weeks
Due to Hypertension Cardiovascular Renal disease	several years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Truman V. Mullins M. D.

Address 610 W 39th St Date signed 7-21-44

G19188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 93 D

G19188

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1122 N 6th Ave St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 9 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Va. (b) County

(c) City or town Lynchburg, Va.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1916 Floyd St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Essie Bacon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-1906

8. AGE: Years	Months	Days	If less than one day
38	4	13	hr. min.

9. Birthplace Lynchburg, Va.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER — 12. Name Willis Bacon

13. Birthplace Va.

MOTHER — 14. Maiden Name Nannie Toler

15. Birthplace Va.

16 (a) Informant Almo Marshall

(b) Address 1411 Pierce St Lynchburg Va

17 (a) Interment Transportation (b) Date thereof 7-21-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Forest Hill

Location Lynchburg Va.

18 (a) Funeral director Williston E. Dulaney

(b) Address 916 Penna. Ave.

19 (a) JUL 21 1944 (b) Registrar
(Date received by local registrar) Livingston Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 1944 at 12:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 19 1944 to July 21 1944 and that I last saw alive on 19

Immediate cause of death

Hypertensive Cardio Vascular Disease — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. K. Adams M. D.

Address 1222 N. Carolina Date signed 7-21-44

G19189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19189
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address V. A. M. H. a
(c) Hospital or institution: 304 Monument St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Worcester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold B. Brothers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14, 1915

8. AGE: Years 29 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Worchester, Mass (Town, county, and state)

10. Usual Occupation Soldier

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Army Records
(b) Address Fort Geo. G. Meade, Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/21/44 (month) (day) (year)
(c) Cemetery or crematory Worchester, Mass
Location Worchester

18 (a) Funeral director Howard V. Blight
(b) Address 4914 Belair Road.

(a) Filed by registrar (b) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h— alive on 19

Immediate cause of death: acute cardiac Dilatation due to Arteriosclerotic Fibrosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Foster Sabo 1st Lt MC M. D.

Address ARMed Forces Date signed July 21, 44

Induction Station Balto. Md

G19190 BALTIMORE CITY HEALTH DEPARTMENT G19190
CERTIFICATE OF DEATH 93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2173 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES J. WOODHOUSE

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-3906

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose E. Woodhouse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27-1885

8. AGE: Years 59 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Assistant Shipping Clerk

11. Industry or business Ingram & Bond

FATHER 12. Name James Henry Woodhouse

13. Birthplace England

MOTHER 14. Maiden Name Margaret Perkins

15. Birthplace England

16 (a) Informant Mrs. Rose Emma Woodhouse

(b) Address 2173 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-1944 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet

Location Baltimore Md.

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Ave.

19 (a) Date received by local registrar JUL 22 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1944 at 8 a M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis cardiovascular

Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wollenweber M.D. Asst. Medical Examiner.

Date signed 7-21-44

VS 151

G19191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 488

G19191 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 W. Cullen St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 W. Cullen
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Irene Lurvey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 1879

8. AGE: Years	Months	Days	If less than one day
64	9	11	hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Thomas Cane
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Cora —
15. Birthplace Calvert Co. Md.

16 (a) Informant Helena Thomas
(b) Address 211 W. Cullen

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-21-44
(month) (day) (year)
(c) Cemetery or crematory Mt. Andrew Cemetery
Location Baltimore Md.

18 (a) Funeral director Clifford C. Gallion
(b) Address 2101 W. Cullen St.

JUL 22 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 19 1944, and that I last saw her alive on July 19 1944.

Immediate cause of death Acute Leucocytosis — Duration 1 day

Due to Chr. Nephritis — Duration 6 mos.

Due to Carcinoma of uterus — Duration 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lou. L. Lurvey M. D.
Address 1420 E. Chase Date signed July 20 44

G19192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G19192 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4317 Bergen ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Bergen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew P. McGarrigel Sr.

3 (b) If veteran, name war none | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Augusta McGarrigel
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) November 17, 1867

8. AGE: Years 76 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Philadelphia Pa. (town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER: 12. Name ✓ 13. Birthplace ✓

MOTHER: 14. Maiden Name ✓ 15. Birthplace ✓

16 (a) Informant Andrew McGarrigel, Jr.
(b) Address 4317 Bergen ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Taylor ave

18 (a) Funeral director Howard H. Blight, Jr.
(b) Address 4914 Belair Road

19 July 22 1944 (Date received by local registrar) Huntington Williams M.D. (Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1944, at 3:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21, 1943, to July 21, 1944, and that I last saw h[illegible] alive on July 21 1944

Immediate cause of death Carcinoma of Stomach
Cardiac Failure
Due to Myocarditis
Due to
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations:
of autopsy:

Duration 3 Years 2 Weeks 2 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lachman, M. D.
Address 4530 Belair Rd Date signed July 23 1944

VS 150

G19193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G19193 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 553 Mc Mechen St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Verry Christmas 99894

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 | 30 | 44

8. AGE: Years | Months: 2 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Balto, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Charles Smith
13. Birthplace: Balto, Md

MOTHER 14. Maiden Name: Doris Christmas
15. Birthplace: Balto, Md

16 (a) Informant: Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 21 1944

18 (a) Funeral director: Commissioner of Health
(b) Address
JUL 22 1944 (c) Hunting Town Williams MD
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 44, at 5 O.E. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 12 1944 and that I last saw h[illegible] alive on July 12 1944.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions Otitis media

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed 7/13/44

2017

G19194

T.G.P.--59301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19194 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital of inst. (yrs., mos., or days) 3 yrs. 9 Mo. 22 days 2 22 1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 W. Henrietta Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rose Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife William Ward (d) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1875 ?

8. AGE: Years	Months	Days	If less than one day
68 ?	10 ?	18 ?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Carl Netter
13. Birthplace Maryland

MOTHER
14. Maiden Name Lena Jane Prout
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 21 1944
18 (a) Funeral director Commissioner of Health
(b) Address
19 JUL 22 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1944, 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9 1944 to 7/10 1944, and that I last saw h.m. alive on 7/10 1944.

Immediate cause of death: Bronchopneumonia
HCVD — Duration: 1 Wk ?

Due to

Due to

Other Conditions: Hypertrophic arthritis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address Balt. City Hosp. Date signed 7/20/44

2015

G19185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19195

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Curley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS H. SHANK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-16-1887 (1877)

8. AGE: Years 67 | Months 6 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Night WATCHMAN

11. Industry or business Helvig & Leach

FATHER
12. Name John Shank
13. Birthplace Pa.

MOTHER
14. Maiden Name ?
15. Birthplace Pa.

16 (a) Informant Eva Shank
(b) Address 16 N. Curley ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Frederic Rd.

18 (a) Funeral director John C. Mosan
(b) Address 3000 E Baltimore St

19 (a) JUL 22 1944 (Local registrar) Huntington Hilleary M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 4 17 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 7-20-44

VS 151

G19196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G19196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E Monument St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** LEMUEL CARR

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Carr

6 (c) If alive, give age .....

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 Months . Days . If less than one day ..... hr. ..... min.

9. Birthplace Cambridge Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business .....

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary Carr, (wife)
(b) Address 1018 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 24 44 (month) (day) (year)

(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St E

19 JUL 22 1944 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 8 50 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis
carbuncle
Due to disease
.....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 7-20-44

G19197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G19197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 830 Abbott Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 10-2
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 830 Abbott Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Rose Gangi

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Salvatore Gangi

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2, 1898

8. AGE: Years: 46 Months: 2 Days: 19 If less than one day: hr. min.

9. Birthplace: Sicily (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER: 12. Name: Joseph Rappa
13. Birthplace: Sicily

MOTHER: 14. Maiden Name: Frances (Unknown)
15. Birthplace: Sicily

16 (a) Informant: Salvatore Gangi
(b) Address: 830 Abbott Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: July 23, 1944 (month) (day) (year)
(c) Cemetery or crematory: Lawrence Cemetery
Location: Lawrence, Mass.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) (Date rec'd by registrar) Lewington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1944, at 3:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 15 1944 to July 21 1944 and that I last saw deceased alive on 7/18 1944

Immediate cause of death: Hypertensive C.V. disease — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Charles D. Garcia M.D.
Address: 801 Fairmount Ave Date signed: 7/21/44

G19198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 E Lost Alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town NORWOOD, PA. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. RUSSELL

3 (b) If veteran, name war

3 (c) Social Security Account No. 180-14-1848

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED.

6 (b) Name of husband or wife JESSIE E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 28, 1877

8. AGE: Years	Months	Days	If less than one day
66	10	23	hr. min.

9. Birthplace ENGLAND. (Town, county, and state)
10. Usual Occupation BARGE CAPTAIN
11. Industry or business S. C. LOVELAND Co.

FATHER
12. Name JAMES W. RUSSELL
13. Birthplace ENGLAND.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ENGLAND.

16 (a) Informant JESSIE E. RUSSELL
(b) Address NORWOOD, PA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 7-22-44 (month) (day) (year)
(c) Cemetery or crematory
Location NORWOOD, PA.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUL 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21- 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH ?

Due to

Other Conditions Completely decomposed - externally & internally.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 7-22-44

VS 151

G19199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19199 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4218 Connecticut Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4218 Connecticut Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine S. Ganter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife Charles F. W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1872

8. AGE: Years	Months	Days	If less than one day
72	1	18	hr. min.

9. Birthplace Baltimore, Maryladd (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Carl Spoerer
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte Scheidt
15. Birthplace Germany

16 (a) Informant Victoria J. Ganter
(b) Address 4218 Connecticut Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24144 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 7/22/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21 1944 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1944 to 7-21 1944 and that I last saw h. w alive on 3-27 1944.

Immediate cause of death Acute Cardiac Failure — Duration 1 dy.
Due to Chronic Myocarditis
Due to Diabetis Mellitus
Other Conditions Carcinoma Rectum & Sigmoid
Carcinoma Stomach
5 mths thats
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph H. Lankarter M. D.
Address 29 Washington Blvd Date signed 7/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19200

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 529 W Cross St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d

(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)

(d) Street No. 529 W. Cross St (if rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary C Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/1893

8. AGE: Years	Months	Days	If less than one day
51	6	14	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Filled Illegible

13. Birthplace N. C.

MOTHER 14. Maiden Name Eliza Sumner

15. Birthplace

16 (a) Informant James P. Campbell

(b) Address 529 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A A. Co. Md

18 (a) Funeral director Isaac L Brown Son

(b) Address 1084 Monty omery St

19 JUL 22 1944 (b) Huntington Williams, M.D. Address 817 Hamilton Ter Date signed

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1944 to July 20 1944 and that I last saw her alive on July 19 1944

Immediate cause of death Cerebral Hemorrhage — Duration 7 Days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H C Pettetcrim M. D.

G19201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G19201

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 E. 30th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E 30th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD ADAM WINTZ

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 220-14-5620

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene Wintz

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1892

8. AGE: Years 51 | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Ins. Agent. Ret. 2 yrs.

11. Industry or business

FATHER
12. Name Edward Wintz
13. Birthplace France

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Edward A. Wintz
(b) Address 1616 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Avenue & Broadway

19 (a) JUL 22 1944 (Date rec'd by registrar) Huntington [illegible], Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944 to July 20 1944 and that I last saw him alive on June 19 1944

	Duration
Immediate cause of death: Renal Requrgitation	
Decompensation	2 mo
Due to:	
Due to: Chr. Pyelonephritis	
Pare chymatous Nephritis	2 mo
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature S F A Stevens
Address 2878 Harford Rd Date signed 7/25/44

G19202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19202 Registered No. 1316

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4437 Belair Road
(c) Hospital or institution: Seidel Apt.# 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

26-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County paltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4437 pelair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY EMMA SHIMP

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Harry Montgomery Shimp
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1886

8. AGE: Years	Months	Days	If less than one day
57	9	7	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Henry McDowell
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Loretta Mitchell
15. Birthplace Baltimore, Md

16 (a) Informant Harry M. Shimp
(b) Address 4437 pelair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-22-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) JUL 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1944, at 8. P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 2 1944 to July 18 1944. and that I last saw h.er alive on July 18 1944

Immediate cause of death.	Duration
Cardiac Failure	
Due to Apoplexy	
Due to Chr. Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C Monninger M. D.
Address 800 E North Ave Date signed 7/20/44

VS 150

G19203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G19203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harrow Court, City Harbor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Hooker Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-4-35

8. AGE: Years 8 Months 9 Days 8 If less than one day hr. min. 17

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Jones
13. Birthplace Jackson, N.C.

MOTHER 14. Maiden Name Mary E. Williams
15. Birthplace Jackson, N.C.

16 (a) Informant Mary W. Jones, Fairfield
(b) Address 1311 Hooker Ct. Fairfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co., Md.

18 (a) Funeral director Charley R. Law
(b) Address 802 Madison Ave.

19 (a) 7/22/44 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21- 1944, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/6

(a) Date of injury 7-21-44 at 3.45 P.M.
(b) Where did injury occur? City Harbor, at Harrow Court
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell into harbor -

23. Signature Howard J. Anderson M.D. Medical Examiner.
Date signed 7-22-44

G19204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Raymond Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY LEE WARREN
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1879

8. AGE: Years	Months	Days	If less than one day
65	2	13	hr. min.

9. Birthplace Reisterstown Md (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Shipyard

FATHER
12. Name Aaron Warren
13. Birthplace Reisterstown Md

MOTHER
14. Maiden Name Matilda Gardner
15. Birthplace Reisterstown Md

16 (a) Informant Enid Warren
(b) Address 2259 Sidney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/44 (month) (day) (year)
(c) Cemetery or crematory Parkland Cemetery
Location Reisterstown Md

18 (a) Funeral director Gore & Kenny
(b) Address Reisterstown Maryland
(c) (Date rec'd by registrar) Registrar

JUL 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 1:30 P.M

21. I certify that I took charge of the remains described above, held an autopsy and inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 7-20-44

VS 151

G19205
AB-88976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

14

G19205
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L Brewer
3 (b) If veteran, name war W
3 (c) Social Security Account No. 034-10-9804
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?-?-1918?
8. AGE: Years 26 ? Months ? Days ? If less than one day hr. min.
9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business

FATHER
12. Name Frank H Brewer
13. Birthplace Burlington Mass

MOTHER
14. Maiden Name Etta Westover
15. Birthplace Canada

16 (a) Informant Etta M. Brewer
(b) Address Andover Mass
17 (a) Burial, cremation, or removal Burial (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Burlington Mass
18 (a) Funeral director Welborn Corp Inc
(b) Address 1219 Druid Pk
19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar) JUL 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-44 19 at 2:25 M
21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1944 to 7-21 1944 and that I last saw h[illegible] alive on 7-21 1944.
Immediate cause of death tuberculous meningitis — Duration 2 wks ?
Due to
Due to
Other Conditions 1
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Tuberculosis & Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas Perry Jr. M.D.
Address City Hosp Date signed 7-23-44

G19206 Fisher ✓ G19206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 290 E Biddle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Henry M. Fisher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ada
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1865

8. AGE: Years	Months	Days	If less than one day
78	8	8	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Fisher
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Mrs. Fisher
(b) Address 3760 Dolfield Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton ave, Rosedale

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1134-26 W. North ave

19 (a) JUL 31 1944 (Date rec'd by registrar) Herrington for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1944 to 7/22 1944, and that I last saw h[illegible] alive on 7/22 1944

Immediate cause of death Acute Bronchitis
Failure, Pulmonary edema, Bronchopneumonia — Duration

Due to Hyp. Cardiovascular Disease, Arteriosclerosis, Hypertension

Due to Coronary Sclerosis

Due to Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Cuna
Address Sinai Hospital Date signed 7/27/44 (M.) (D.)

G19207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19207 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cloverdale Rd. & MadisonAve.
(c) Hospital or institution: Temple Garden Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME JONAS SIMON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1883.

8. AGE: Years 61 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER
12. Name Isaac Simon,
13. Birthplace Germany.

MOTHER
14. Maiden Name Clara Heinsfurter,
15. Birthplace Germany.

16 (a) Informant Miss. Theresa Simon,
(b) Address Temple Garden Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44. (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levi Sons
(b) Address 1902 Eutaw Place.

19 (a) 7-23-1944 (registrar) (b) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22nd. 1944, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1928. to July 22 1944. and that I last saw h[illegible] alive on July 21 1944.

Immediate cause of death: Congestive heart failure — Duration: 19 days

Due to: Myocardial infarction

Due to: Coronary art. thrombosis

Other Conditions: Disseminated Sclerosis 16 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M.D.
Address 1207 Eutaw Place. Date signed 7/23/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G19208 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Whitelock St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR and give county)
(d) Street No. 1011 Whitelock St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amaza R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1878

8. AGE: Years 66 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Henderson, N. C. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER — 12. Name N. M. Faulkner

FATHER — 13. Birthplace North Carolina

MOTHER — 14. Maiden Name Alice Garland

MOTHER — 15. Birthplace Va

16 (a) Informant Amaza R. Faulkner

(b) Address 1011 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23, 1944 (month) (day) (year)

(c) Cemetery or crematory

Location Norfolk, Va

18 (a) Funeral director Mrs. Kay. H. Hallard

(b) Address 1651 Druid Hill Ave

19 (a) July 23 1944 (Date registered) (b) Registrar

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 5.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1944 to July 20 1944, and that I last saw him alive on July 20 1944

Immediate cause of death	Duration
Carcinoma of Rectum	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature M. E. Wilson, M.D.

Address 803 N. Arlington Ave Date signed July 23 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17205 1/2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 19208 1/2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ~~1839 Ed~~
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Gilliard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/15/44

8. AGE: Years: Newborn | Months | Days | If less than one day: 2 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name David Gilford
13. Birthplace Darlington, S.C.

MOTHER
14. Maiden Name Daisy Berry
15. Birthplace Darlington, S.C.

16 (a) Informant Daisy Gilford (mother)
(b) Address 1839 E. Chase St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1944 to July 15, 1944, and that I last saw h[illegible] alive on July 15 1944.

Immediate cause of death	Duration
Congenital Atelectasis	2 hr.
Due to Uncertain	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Thorn, M. D.
Address 312 E. 23rd St. Date signed 7-20-44

2014

G19209 BALTIMORE CITY HEALTH DEPARTMENT G19209

CERTIFICATE OF DEATH 1131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr.M.Optata Mich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29,1889

8. AGE: Years	Months	Days	If less than one day
55	2	22	hr. min.

9. Birthplace Eronima Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Religious

FATHER
12. Name George Mich
13. Birthplace Bucks County

MOTHER
14. Maiden Name Anastasia Heaney
15. Birthplace Bucks County

16 (a) Informant Sr.M.Stan.Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24th 44 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glen Arm

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811 N. Wolfe. St

19 (a) JUL 28 1944 (registrar) Huntington Williams M.D.
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 44, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan.6 19 34, to July 21 19 44, and that I last saw h er alive on July 20 19 44.

Immediate cause of death Arterio sclerosis - Chr Myocarditis. — Duration

Due to Chronic nephritis

Due to Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operations:

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. J. Kirby M. D.
Address 1106 Northern Ave Date signed 8/26/44

G19210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G19210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 E. Balto. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Aaron Bataleon

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-3553

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Bataleon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name David
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Ida Bataleon
(b) Address 1524 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Jos Lewis Inc

18 (a) Funeral director Jos Lewis Inc
(b) Address E. Balto St

JUL 23 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22-44 19 , at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1936 to July 22 19XX; and that I last saw him alive on July 21 19XX.

Immediate cause of death	Duration
Myocarditis	
Due to Coronary sclerosis	
Due to Bronchopneumonia	
Other Conditions Lymphoid atrophy	

(Include pregnancy within 3 months of death)
Date of operation July 20, 1944
Major findings of operation Biopsies — Pneumonia (no autopsy)
~~of autopsy~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Snyder M. D.
Address 1634 E. Baltimore Date signed 7/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

[redacted] G19211 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

[redacted] G19211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 N. Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wolfe Berlin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel St

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Balto St

JUL 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-44 19 , at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1941 to July 21 1944, and that I last saw h[redacted] alive on July 21 1944

Immediate cause of death: Coronary Occlusion — Duration: 20 Min.
Due to: Athero-sclerosis — 10 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Sinai M. D.
Address 14 S. [redacted] Date signed 7/22/44

G19212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1938

Registered No. G19212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Golden Ring Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Evering Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine E. Evering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21-1882

8. AGE: Years	Months	Days	If less than one day
62	6		hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Filling Station Prop.
11. Industry or business

FATHER
12. Name Christian Evering
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Shuler
15. Birthplace Balto. Md.

16 (a) Informant Katherine E. Evering
(b) Address Golden Ring Rd. Balto. Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-44 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Cem.
Location Taylor Ave.

18 (a) Funeral director John A. Miller
(b) Address 233 N Jefferson St.

19 (a) (Date rec'd by registrar) JUL 23 1944 (b) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1944 at 1140 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1944 to 7/21 1944 and that I last saw him alive on 7/21 1944

Immediate cause of death Myocardial insufficiency — Duration

Due to Coronary occlusion

Due to Arteriosclerotic H. dis.

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward
Address Sinai Hosp. Date signed 7/21/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 149a

G19213
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town McPhersons, Baltors Route 9 Box 377
(If outside city or town limits, write RURAL and give town)
(d) Street No. Near Dobsey Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Disney

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1896

8. AGE: Years	Months	Days	If less than one day
47	8	27	hr. min.

9. Birthplace Ft. Meyer Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Summerfield Disney
13. Birthplace Md. (No. Morrell Pk.

MOTHER
14. Maiden Name Estelle Mullineaux
15. Birthplace Md. A. A. Co

16 (a) Informant Summerfield Disney
(b) Address Balto 25, Route 9 - Box 377

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1944 (month) (day) (year)

(c) Cemetery or crematory Friendship
Location Ft. Meade Road A. A. Co. Md

18 (a) Funeral director Thomas W. Dougherty
(b) Address Glen Burnie, Md

(Signature of registrant) Huntington Williams, M.D.

JUL 23 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on July 29 1944

Immediate cause of death
Malignant tumor, left ovary
Amyotrophic lateral sclerosis

Duration
?
?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July 21, 1944
Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn O. Swinnerton, M.D.
M. D.

Address Univ. Hosp. Date signed 7/24/44

G19214
A36512

BALTIMORE CITY HEALTH DEPARTMENT X V G19214

CERTIFICATE OF DEATH

157 M

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town P.O. York, New Salem
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy K. Lehr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-44

8. AGE: Years	Months	Days	If less than one day
	5	14	hr. min.

9. Birthplace PA. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name IVAN Lehr
13. Birthplace PA.

MOTHER
14. Maiden Name Esther Stump
15. Birthplace PA.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1944 (month) (day) (year)
(c) Cemetery or crematory York New Salem Cem. Co.
Location York New Salem, Pa.

18 (a) Funeral director C. O. Gladfelter
(b) Address Seven Valley, Pa.

19 JUL 24 1944 (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH [redacted] July 23 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 23 1944 and that I last saw her alive on July 23 1944

Immediate cause of death: Respiratory failure — Duration: 2 days

Due to peritonitis (postoperative) — 5 mos

Due to biliary atresia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: biliary atresia

of autopsy: biliary atresia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp Date signed 7-23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. G19215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry and Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Timothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1882

8. AGE: Years	Months	Days	If less than one day
62	3	6	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Lahyne
13. Birthplace Ireland

MOTHER
14. Maiden Name ~
15. Birthplace ~

16 (a) Informant Timothy J. Hayes
(b) Address 510 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Durward A Covington
(b) Address 21 W. 25th St.

19 (a) (date received) (b) Huntington Williams, M.D.
JUL 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1944, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1944 to 7-22 1944, and that I last saw her alive on 7-22 1944.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease with	
Due to Decompensation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.
Address St. Agnes Hosp. Date signed 7/22/44

G19216

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 157E

Registered No. G19216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Balt. Co. Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 S. Railroad Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Horton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-19-44

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace W. B. D. H. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Fairy Horton
13. Birthplace Paris Georgia

MOTHER 14. Maiden name Catherine Hoffler
15. Birthplace Balt. Md

16 (a) Informant Mrs Catherine Horton
(b) Address 409 S. Railroad Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 24 1944 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1944, at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944, to July 21 1944, and that I last saw him alive on July 21 1944.

Immediate cause of death Cerebral Hemorrhage Duration
Patent foramen ovale enlarged Atrium septi
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lockhart Badenoch
Address W B & H Date signed 7/21/44 M. D.

2020

G19217

BALTIMORE CITY HEALTH DEPARTMENT X 159 ✓ G19217

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 874 Washington Blvd
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Garden Ave, Halethorpe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bowling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/44

8. AGE: Years | Months | Days | If less than one day: 11 hr. 5 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Orrin Bowling
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Pugh
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 22 1944

18 (a) Funeral director
(b) Address Commissioner of Health

19 JUL 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

2021

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1944, at 8 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20-1944, to 7-22 1944, and that I last saw h... alive on 7-21-1944.

Immediate cause of death	Duration
Atelectasis	
Due to	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Hoffman M. D.
Address 876 Worthington Blvd Date signed 7/24/44

G19218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G19218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Norfolk ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Norfolk ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Late Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs Anna Wolfman
(b) Address 2814 Norfolk ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton ave

18 (a) Funeral director A. L. Levinson & Bro.
(b) Address 1024-26 W. North ave

19 (a) JUL 24 1944 (b) Huntington Millinery, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944, at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944 to July 23 1944 and that I last saw h[illegible] alive on July 23 1944

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Hypertension

Due to

Other Conditions Chronic hypertension Nephrosclerosis. Right leg amputated

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Sharfstein M.D.
Address 5106 Park Heights ave Date signed 7/23/44 M. D.

G19219

JO #86001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

Registered No. G19219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo 28 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 McMechen St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Purnell Copper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1894

8. AGE: Years	Months	Days	If less than one day
49	7	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John T. Copper
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary L. Thomas
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Jas Brookes
(b) Address 1462 N. Carey St

19 JUL 24 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1944, at 4:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22, 1944, to July 20, 1944, and that I last saw h im alive on 7/20/44 19

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Parry M. D.
Address City Hosp. Date signed 7-21-44

G19220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19220 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John L Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife EMMA J.

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) JULY 19 1875

8. AGE: Years 69 | Months 0 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business B+O RR-ENGINER

FATHER 12. Name JOHN H HOFFMAN

FATHER 13. Birthplace DEL.

MOTHER 14. Maiden Name CATHERINE WEAVER

MOTHER 15. Birthplace NOT KNOWN

16 (a) Informant EMMA J. HOFFMAN

(b) Address GREEN HAVEN A A Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A. A Co

18 (a) Funeral director Bernard C Healy

(b) Address 121 E West St

19 (a) JUL 24 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21- 19 KK, at 7 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed 7-22-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G19221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Hennessy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Kitzo
15. Birthplace Ireland

16 (a) Informant Little Sister of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Wash. D. C.

18 (a) Funeral director Rita Windfeld
(b) Address 914 Fremont Ave

19 JUL 24 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 6.309

20. DATE OF DEATH July 22 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to July 22 1944 and that I last saw h— alive on 19

Immediate cause of death	Duration
General toxemia	
Due to Chr Nephritis	
Due to Chr Myocarditis	
Other Conditions Chr Hypertension	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otto H. Duke M.D.
Address 928 E. North Ave Date signed 7/25/44

G19222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 ✓

G19222 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 Baldwin St
(c) Hospital or institution: BALDWIN

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 Baldwin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FLETA B. WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edgar L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1892

8. AGE: Years 52 ✓ Months 1 Days 21 If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles E. Crawford
13. Birthplace Va.

MOTHER
14. Maiden Name Mandy Doffelmeyer
15. Birthplace Va.

16 (a) Informant Edgar L. Williams
(b) Address 1534 Baldwin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden

18 (a) Funeral director Edmondson & Donovan
(b) Address 2615-17 Eastern Ave

19 JUL 24 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 11 55 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenweber M.D.
Medical Examiner.
Date signed 7-23-44

G19223 X ✓ G19223

G19223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41da.
(e) Length of stay in Baltimore (yrs., mos., or days) 41da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Smithfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Cora Lee Chapman

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) April 14, 1879

8. AGE: Years	Months	Days	If less than one day
65	3	9	hr. min.

9. Birthplace Smithfield, Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benj. P. Chapman
13. Birthplace Va

MOTHER
14. Maiden Name Florence Britt
15. Birthplace Va

16 (a) Informant H. C. Baugh
(b) Address 200 Investment Bldg. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25/44 (month) (day) (year)
(c) Cemetery or crematory Smithfield Va
Location Smithfield Va

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place

19 JUL 24 1944 (b) Huntington Williams M.D. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944, at 1230 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1944, to July 23 1944 and that I last saw her alive on July 23 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Terminal bronchial pneumania	2 da.
Due to Lymphosarcoma	4 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 17, 1944
Major findings of operation: Biopsy of Neck showed Lymphosarcoma
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.
Address Women's Hospital Date signed 7/28/44

G19224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves
(c) Hospital or institution:
St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Merridale (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Plymouth Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Marling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name ~~of husband or wife~~ Lorin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1872

8. AGE: Years 71 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Ill. (Town, county, and state)

10. Usual Occupation Construction Supt

11. Industry or business Better Homes Corp.

FATHER — 12. Name Augustus Marling

13. Birthplace England

MOTHER — 14. Maiden Name Ruth Laurence

15. Birthplace England

16 (a) Informant Mrs. Lorin Marling

(b) Address 628 Plymouth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Wiltz

(b) Address 4101 E. Monument Ave

JUL 24 1944 (Date filed) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-20 1944, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1944 to 7-20 1944, and that I last saw h. l. M. alive on 7-20 1944

Immediate cause of death: Coronary [redacted] Thrombosis

Due to: [redacted] arteriosclerosis

Due to: H.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address 5 E. Lexington St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d Registered No. G19225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sewell S. Sutherland

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Estella M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1881

8. AGE: Years 63 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Expeditor

11. Industry or business Printing

FATHER 12. Name George A. Sutherland

FATHER 13. Birthplace Scotland.

MOTHER 14. Maiden Name Susan Baker

MOTHER 15. Birthplace Md.

16 (a) Informant Mr. G. Ashton Sutherland

(b) Address 613 Gittings Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (Date rec'd by registrar) JUL 24 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-44 19 , at 3 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15-44 19 , to 7-23-44 , and that I last saw h IM alive on 7-23-44

Immediate cause of death Cardiac Failure — Duration

Due to Arterio-sclerotic

Due to Cardio-vascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Reynolds Ford Jr. M.D.

Address Univ. Hosp. Date signed 7-25-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

G19226 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 Gwynn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilford Rolland Fleming

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	212-05-4535

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna May (Jamison)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1896

8. AGE: Years	Months	Days	If less than one day
47	9	11	hr. min.

9. Birthplace Kansas (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Gas & Electric Co.

FATHER
12. Name -- Fleming
13. Birthplace unknwon

MOTHER
14. Maiden Name Dona May
15. Birthplace Unknown

16 (a) Informant Mrs. Ann May Fleming
(b) Address 431 Gwynn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l. Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) JUL 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944, at 12 P M

21. I certify that I took charge of the remains described above, held an Inquiry - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Walter L. Zalenski M.D. Medical Examiner.
Date signed 7/27/44

VS 151

S 1927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. S 1927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Guilford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl S. Appel

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 215-12-4376

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Pauline M. Appel
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 27, 1898

8. AGE: Years 46 | Months 1 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Radio Technician
11. Industry or business Radio Mfg.

FATHER
12. Name Charles H. Appel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary T. Van Daniker
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Pauline M. Appel
(b) Address 3112 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miles Lawrence
(b) Address 1005 W. Baltimore St. Huntington Williams, M.D.

19 (a) JUL 24 1944 (Date rec'd by local reg.) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 7/21 1944 and that I last saw h in alive on 7/21 1944

Immediate cause of death: Coronary Thrombosis — Duration: 14 Days

Due to Hypertension Cardio-Vascular Disease — Duration: Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. Giesboro M. D.
Address 2923 St. Paul St. Date signed

G19228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 G 19228 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 240 S. Conklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 240 S. Conklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Glasgey.
3 (b) If veteran, name war ns. 3 (c) Social Security Account No. ns.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Benjamine Glasgey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 19. 1863

8. AGE: Years	Months	Days	If less than one day
81.	5.	4	hr. min.

9. Birthplace Baltimore (Town, county and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William. Taylor
13. Birthplace S Pain

MOTHER
14. Maiden Name Rose. Buchhouse
15. Birthplace Germany.

16 (a) Informant Florence Lesher
(b) Address 246. S. Conklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24. 1944 (month) (day) (year)
(c) Cemetery or crematory Oak. Lawn.
Location Eastern ave. Road.

18 (a) Funeral director Wendell J. Dippel
(b) Address 312. S. Highland ave

19 (a) 24 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1944, at 10 45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1934 to July 21 1944 and that I last saw h alive on July 21 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	Sudden
Due to Hypertension	10 years
Due to Cardia Vascular Disease	" "
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. L. Mazer
Address Kent & Belleview Date signed 7/25/44 M. D.

M. L. Mazer

Geo. L. Allen

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19229 Registered No. 108 G19229

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 St. Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town ✓ (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joana Bartee ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1944 at 9:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 15th 1944, to July 20 1944 and that I last saw deceased alive on July 19 1944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1881

8. AGE: Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Hills

13. Birthplace Va.

MOTHER 14. Maiden Name Nancy Carter

15. Birthplace Va.

16 (a) Informant William J. Bartee

(b) Address 522 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Robert W. Williams

(b) Address 1515 McElderry St

19 (a) Date received 7-24-1944 (b) Huntington Williams, M.D.

Immediate cause of death: Acute Lobar Pneumonia — Duration: July 19 - 44

Due to: Cold

Due to:

Other Conditions W

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

If autopsy

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Geo. L. Allen M.D.

Address 121 Dugan St Date signed July 21-44

VS 150

G19230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19230 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Mt. Royal Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Mt Royal Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES A ~~(KAVANAUGH)~~ Kavanagh.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex m | 5. Color or race w | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13-1877

8. AGE: Years 67 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Ellicott City.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Ship Yards

FATHER
12. Name Martin J. Kavanagh
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Faherty
15. Birthplace Ireland

16 (a) Informant William M. Kavanagh.
(b) Address 1518 Mt. Royal Ave

17 (a) Burial (b) Date thereof 7/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director H. W. Meadow
(b) Address 1405 N. Calvert St.,

19 (a) (b) Huntington Hill, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 1.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
cardiorenal
Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 7-25-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G19231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Columbia
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Avis Jane Yost

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1941

8. AGE: Years 2 | Months 7 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Columbia Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Yost
13. Birthplace Pa.

MOTHER
14. Maiden Name Gemmill Risking
15. Birthplace Pa

16 (a) Informant Charles Etzweiler
(b) Address Columbia Pa.

17 (a) removal (b) Date thereof 2-24-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Columbia Pa.

18 (a) Funeral director Jno. J. Tickner & Sons
(b) Address 340 N. Penna Ave.

JUL 24 1944
(Date rec'd by registrar) Huntington Williamsport

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1944, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-23- at 4:10 P.M.
(b) Where did injury occur? Susq. River Bridge, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury While playing pulled into water

23. Signature Howard J. Kleinfelter M.D.
Medical Examiner.
Date signed 7-24-44

G19232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3421 Parklawn Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. West Twin River Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BARBARA CATHERINE PLETSCH

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howell G. Pletsch
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1884

8. AGE: Years 59 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Colombia, Penna.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Andrew J. Kraft
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Baker
15. Birthplace ?

16 (a) Informant Mr. Howell G. Pletsch
(b) Address 3421 Parklawn Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (b) Huntington Williams, M.D.

JUL 24 1944
VS 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH July 22, 1944 at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1944 to July 22 1944, and that I last saw h alive on 19

	Duration
Immediate cause of death Mitral Regurgitation Decompensated	4 mo
Due to Arteriosclerosis Hypertension	4 mo 4 mo
Due to Chr. Parenchymatous Nephritis	4 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T F A Stevens M. D.
Address 2878 Harford Rd Date signed 7 22 44

G19233 325-415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G19233 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NETTIE MABEL KALBFUS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-82

8. AGE: Years	Months	Days	If less than one day
62	6	17	hr. min.

9. Birthplace Md, Baltimore (Town, county and state)
10. Usual Occupation Sales Lady
11. Industry or business Goodwill Ind.

FATHER
12. Name William Kalbfus
13. Birthplace Md.

MOTHER
14. Maiden Name Jeannette Whitten
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 26-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address North Ave. & Broadway

19 (a) (Date received by registrar) JUL 24 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944 at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 23 1944 and that I last saw her alive on July 23 1944

Immediate cause of death	Duration
(a) Peritonitis	
Due to (b) Postoperative complication	
Due to (c) Pneumonia, Terminal	
Due to	
Other Conditions Post operative Ca of colon	

(Include pregnancy within 3 months of death)
Date of operation 7-17-44
Major findings of operation: descending Ca Colon
of autopsy Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Burch, M.D. Address J. H. H. Date signed 7-24-44

G19234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 N

G19234 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 Clarkson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Clarkson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles N. Gauer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma Gauer
6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Mar 19. 1872

8. AGE: Years: 72 Months: 4 Days: 45 If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Retired B. & O. Patrolman
11. Industry or business:

FATHER
12. Name: John L. Gauer
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Elizabeth Rithmiller
15. Birthplace: Baltimore Md.

16 (a) Informant: Emma Gauer
(b) Address: 1405 Clarkson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 1944 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: City

18 (a) Funeral director: Mrs. John W. Tunfel & Son
(b) Address: 601 W. Fayette St

19 JUL 21 1944 (Date received by Registrar) Huntington for Williams, M.D.

VB 159

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944 at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 44 to July 24 19 44; and that I last saw him alive on July 24 19 44

Immediate cause of death: Carcinoma of Rectum
Arteriosclerotic Heart Disease — Duration: 8 Mo?
Due to:
Due to:
Other Conditions: Cardiac Dilatation Cachexia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: V. M. Mesmer M. D.
Address: 17035 Charles St Date signed 7/27/44

G19235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G19235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2746 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2746 Riggs Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora L. Hartleb

3 (b) If veteran, name war — no
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Bernard B. Hartleb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 - 1867

8. AGE: Years 77 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Daniel Bartz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Frederick B. Hartleb
(b) Address 2746 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director Mr. & Mrs. John W. Tuckey & Son
(b) Address 801 W. Fayette St

19 (a) July 24 1944 Huntington Williamsport, Md.

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944 to July 22 1944 and that I last saw her alive on July 22 1944

Immediate cause of death Uraemia — Duration 8 hrs.

Due to Chr. Parenchymatous nephritis — Duration ?

Due to Chr. Nephritis — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Hackerman M. D.
Address 1136 Poplar Grove St Date signed 7/24/44

G19236 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

[redacted] G19236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MISTAKES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Halcyon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Halcyon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN R. KNOX

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles H. Knox

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1849

8. AGE: Years 95 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Matthias Erdman
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Knox,
(b) Address 2901 Halcyon Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof July 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson

18 (a) Funeral director Ramsburg Funeral Home
(b) Address 7401 Belair Road
Huntington Williams, M.D.

19 [redacted] JUL 24 1944 (b) [redacted]
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22nd, 1944 at 4:05PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944 to July 22 1944 and that I last saw her alive on July 21 1944

Immediate cause of death Arteriosclerotic Heart Disease — Duration [redacted]
Due to Generalized arteriosclerosis — [redacted]
Due to — [redacted]
Other Conditions Fracture of right hip. — 1 week
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/3
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 22 at A. M
(c) Where did injury occur? 2901 Halcyon Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury Slipped on rug & fell.
23. Signature George Dantzer M. D.
Address 4808 Harford Date signed 7/24/44

Approved by Howard J. Mackie, Md., M.D.

G19237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 D

Registered No. G19237

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3714 FAIT AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 3714 FAIT AVE. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARY KALBFLEISCH

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: EDWARD KALBFLEISCH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 15 1877

8. AGE: Years 66 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER

12. Name CASPER KREMER

13. Birthplace GERMANY

MOTHER

14. Maiden Name MELINA GENSLER

15. Birthplace GERMANY

16 (a) Informant EDWARD KALBFLEISCH(HUS.)

(b) Address 3714 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 25/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART CEM.

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc

(b) Address 403 S. WOLFE ST.

19 JUL 24 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 21 1944 at 4/15 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944 to July 21 1944 and that I last saw h.er alive on July 20 1944

Immediate cause of death: Malignancy - neoplasm of left side of rectum with peritonitis

Due to perforation of left side of rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. D. Kelly M. D.

Address 737 S. Patterson Pk. Date signed 7/27/44

O.K. Dr. Mallein, Health Officer

G19238

G19238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Do not abbreviate. Do not use ditto marks. Be sure correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 709 S. GRUNDY ST. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ADRIANUS BOEREN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213 03 8112

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife ANNA M. BOEREN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 16 1885

8. AGE: Years 59 Months 1 Days 6 If less than one day hr. min.

9. Birthplace Holland (Town, county, and state)

10. Usual Occupation BRICKLAYER

11. Industry or business

12. Name of FATHER ADRIANUS BOEREN

13. Birthplace of FATHER HOLLAND

14. Maiden Name of MOTHER HELENA MOSMAN

15. Birthplace of MOTHER HOLLAND

16 (a) Informant JOHN BOEREN (BROTHER)

(b) Address 718 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 27/44 (month) (day) (year)

(c) Cemetery or crematory OAKLAWN

Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 JUL 24 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

ADRIANUS BOEREN

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 10:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1944 to 7/22 1944, and that I last saw h. alive on 7/22 1944

Immediate cause of death	Duration
Peritonitis	
Pulmonary oedema	
Due to carcinoma of Sigmoid	
Due to	
Other Conditions Pyelonephritis Prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 7/15/44

Major findings of operation: CA. of Sigmoid

of autopsy: Carcinoma Sigmoid

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. S Steinberg M. D.

Address Sinai Hospital Date signed 7/23

STEINberg

G19239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1634 Registered No. G19239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin C. Zech

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1908

8. AGE: Years 35 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Shipyard

FATHER
12. Name John Zech
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Katherine Ritterick
15. Birthplace Balto. Md

16 (a) Informant John Zech
(b) Address 3236 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director M. W. E. Dopkins
(b) Address 1600 E. Fort Ave

19 JUL 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24- 1944, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Hemorrhaging Burns.

Other Conditions Dependent

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-24 at A. M.
(b) Where did injury occur? 920 St. Paul St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open gas on kitchen range.

23. Signature Howard J. Malkus M.D. Medical Examiner.
Date signed 7-24-44

G19240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G19240 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamonett Avenue
(c) Hospital or institution: Mrs. Gates Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 12 4
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Pierce

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel W. Pierce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October-16-1883

8. AGE: Years 60 | Months 8 9 | Days 5 | If less than one day: hr. min.

9. Birthplace: Princess Anne, Maryland (Town, county, and state)
10. Usual Occupation: Seamstress
11. Industry or business: Upholstering

FATHER
12. Name: John Hayman
13. Birthplace: Princess Anne, Maryland

MOTHER
14. Maiden Name: Louise Pusey
15. Birthplace: Princess Anne, Maryland

16 (a) Informant: Mrs. Lucy Pierce (self)
(b) Address: 2018 N. Calvert Street, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)
(c) Cemetery or crematory: U. S. National Cemetery
Location: Frederick Ave., at Loudon Park

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 N. North Avenue, City.

JUL 24 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21/44 19 at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5/44 19 to 7/15/44 19, and that I last saw h[illegible] alive on 7/15/44 19

Immediate cause of death: Arteriosclerotic CVHD — Duration
Due to: Congestive Heart Failure — Duration
Due to: Generalized Arteriosclerosis, Chronic Nephritis — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Willard Applegarth M. D.
Address: 2511 Reisterstown Rd. Date signed 7/22/44

G19241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1644

Registered No. G19241

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3464 Cardenas Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GENIVIEVE V. HEUERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Luther H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1906

8. AGE: Years	Months	Days	If less than one day
38	5	0	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name George F. Elliff
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Nannie Grehan
15. Birthplace Va.

16 (a) Informant Husband
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penn. Ave.

19 JUL 24 1944 (Date Rec'd by Registrar) (b) Huntington Williams Mgr

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Hanging by rope

Due to

Other Conditions mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-22-44 at M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury rope

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 7-23-44

G19242 BALTIMORE CITY HEALTH DEPARTMENT G19242

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17d.
(e) Length of stay in Baltimore (yrs., mos., or days) ? yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County -
(c) City or town Baltimore - 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Roslyn Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Raymond Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	M	W	Married

6 (b) Name of husband or wife Edith M.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-21-1873

8. AGE: Years	Months	Days	If less than one day
71	2	26	hr. min.

9. Birthplace Harrisburg Pennsylvania
(Town, county and state)
10. Usual Occupation [illegible]
11. Industry or business Interior Decorater

FATHER
12. Name James Wilson
13. Birthplace Harrisburg Penna.

MOTHER
14. Maiden Name Georgiana Raymond
15. Birthplace Harrisburg Penna.

16 (a) Informant Mrs. Florence Stalzell
(b) Address 2607 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

JUL 24 1944

(a) Registrar (b) Registered Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944, at 11:50 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1944 to July 24 1944, and that I last saw him alive on July 23 1944

Immediate cause of death	Duration
Uremia	2 wks
Due to Arteriolarsclerotic Nephritis	6 mos
Due to	
Other Conditions Angina pectoris	yrs

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Glenn A. Grove
Address Union Memorial Hosp. Date signed 7/24/44 M. D.

G19243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19243 Registered No. 111c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4111 Walrad Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Walrad
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Prendergast

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 12, 1859

8. AGE: Years 85 | Months 2 | Days 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired Painter Foreman
11. Industry or business: Baltimore City

FATHER
12. Name: Anthony Prendergast
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mrs. Mary P. Verleger
(b) Address: 7007 Copleigh Road Balto 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25, 1944 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves.

JUL 24 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to July 22 1944
and that I last saw alive on July 22 1944

Immediate cause of death: Hypostatic Pneumonia — Duration:
Due to:
Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. Williams M. D.
Address 4709 Sinclair Ave. Date signed 7/24/44

G19244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G19244

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Brunt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Brunt St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife James H Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1890

8. AGE: Years	Months	Days	If less than one day
53	6	24 & 25	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name George Bowen
13. Birthplace Md

MOTHER
14. Maiden Name Fannie Pike
15. Birthplace Md

16 (a) Informant Naomi Tyrees
(b) Address 651 Elbow Ln

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Pilgrim Nat
Location Md. U. Kelsey

18 (a) Funeral director
(b) Address 1303 Pennsylvania Ave

19 JUL 24 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 19 44, at 1230 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 19 44, to July 23 19 44, and that I last saw h[illegible] alive on July 22 19 44.

Immediate cause of death	Duration
Diabetes	5 yr.
Due to Cerebral Hemorrhage	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury
Signature William Fley M. D.
Address 928 Penna Ave Date signed 7-27-44

NANNIE

G19245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1157 Mount St. D.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore C.T.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1157 Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie B. Henson

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Les

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/23/1903

8. AGE: Years 41 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Boulden
13. Birthplace Va

MOTHER
14. Maiden Name Laura Wheeler
15. Birthplace Va

16 (a) Informant Les Henson
(b) Address 1157 Mount St

17 (a) Burial (b) Date thereof 7/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Pressman St

19 (a) JUL 24 1944 (Date received by registrar) Lewis Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 19 44 at 1 50 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Clinton J. Subernski M.D.
Medical Examiner.
Date signed 7/25/44

G19246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19246 Registered No. 139a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired into. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Jos. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N. Caroline St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Matilda Howard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25 1886

8. AGE: Years	Months	Days	If less than one day
58	2	26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Stiffelager Ice Co.

FATHER
12. Name William Howard
13. Birthplace Md.

MOTHER
14. Maiden Name Jennie Thomas
15. Birthplace Md.

16 (a) Informant Gertrude Thomack
(b) Address 1023 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. J. Elliott
(b) Address 129 N. Caroline St

19 (a) Date received by registrar JUL 21 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21- 1944 at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3- 1944 to 7-21-1944 and that I last saw h-- alive on 7-21-1944

Immediate cause of death Pulmonary embolism — Duration

Due to

Due to

Other Conditions Hypertension — over

(Include pregnancy within 3 months of death)

Date of operation 7-18-44

Major findings of operation: Exploration of L. kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanni, M.D. M. D.
Address St. Jos. Hosp. Date signed 7-21-44

G19247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G19247 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Scott St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Bruce Smith 305617

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1928

8. AGE: Years 16 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace Mass London Conn
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Barry M Bruce
13. Birthplace Alaska

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace South Bermuda

16 (a) Informant Mary R Bruce
(b) Address 113 Scott St

17 (a) Burial (b) Date thereof 7-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A Cook
(b) Address 1700 N. Lombard St

JUL 24 1944 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 10:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944 to July 22 1944, and that I last saw her alive on July 22 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Postpartum Eclampsia	
Due to	
Other Conditions 24 hrs. Post Partum	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pulmonary Edema, Fatal Convulsive type

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Morrison M. D.
Address Embassy Hosp Date signed 7-22

J. B. J. Morrison

G19248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19248 Registered No. 123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 Mountmor ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1644 Mountmor Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Norman Brown.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Sin

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-7-44

8. AGE: Years | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Eugene Brown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Louise Brooks
15. Birthplace Baltimore, Md.

16 (a) Informant Eugene Brown
(b) Address 1644 Mocentmor Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director Wes. G. Kelson
(b) Address 1313 Pregstman
(c) JUL 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23- 1944 at 12 65 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23-1944 to 7-23-1944 and that I last saw h— alive on — 19

Immediate cause of death Acute Intestinal Colic — Duration 3 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Berg
Address 1516 N. Mocentmor St. (17) Date signed 7-24-44 M.D.

VS 150 For Bd. L. Wellemeyer by Howard J. Mueller, M.D.

G19249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

Registered No. G19249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337 A. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 A Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No).
If yes, name country

3 (a) FULL NAME JAMES TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER 12. Name Arnold Taylor
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Sarah Taylor
(b) Address 1337 Fremont Ave

17 (a) Burial (b) Date thereof 7/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Leg. D. Kelson
(b) Address 1303 Presstman St

19 (a) JUL 24 1944 (b)
(Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944 at 8 05 A M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculosis, pulmonary

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 7-23-44

G19250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19250

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkerson & Caton Aves
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Edgewood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes C. Odail

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Wm. C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1868

8. AGE: Years 76 | Months 5 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Powers

FATHER — 13. Birthplace —

MOTHER — 14. Maiden Name —

MOTHER — 15. Birthplace —

16 (a) Informant Mrs - Robert McGahey

(b) Address 40 N Russell Rd. Alexandria Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 3900 Old Frederick Rd

18 (a) Funeral director Harry M Walther

(b) Address 401 Edmondson Ave Phone Lafayette Huntington for Williams, M.D.

19 (a) ... (b) ... Registrar

JUL 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 1944, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19..., to 7/22 1944, and that I last saw her alive on 7/22 1944

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral Hemorrhage

Due to: Essential Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryson M.D.

Address St. Agnes Hosp. Date signed 7/24/44

G19251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G19251 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Chattam Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Chattam Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence S. Mullinix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida A. Crockett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1876

8. AGE: Years 68 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Salesman

FATHER
12. Name Francis Mullinix
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Ida Mullinix
(b) Address 3809 Chattam Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry D. Wiza
(b) Address 6 Edmondson Ave.

JUL 25 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12, 1941, to July 22, 1944, and that I last saw h[illegible] alive on Oct. 24, 1943

Immediate cause of death Cerebral hemorrhage — Duration Few minutes

Due to Arteriosclerosis — Many years

Due to

Other Conditions Diabetes mellitus — Many years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M.D.
Address 12 E. Eager St. Date signed July 24, 1944

G19252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114d

Registered No. G19252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hospil.
(c) Hospital or institution: 33rd & Calvert St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 Inglewood Ave.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. James Leroy Dix

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
M	W.	

6 (b) Name of husband or wife late Effie M. Nee Hedrick 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-'87

8. AGE: Years	Months	Days	If less than one day
57	6	17	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Seaman.
11. Industry or business Master Mariner

FATHER
12. Name Mr. Samuel Dix
13. Birthplace Maryland.

MOTHER
14. Maiden Name Sarah Carmon
15. Birthplace Maryland.

16 (a) Informant son.
(b) Address same.

17 (a): Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry W. Wilkes
(b) Address 4101 E. Monument St.

19 JUL 25 1944 Huntington Williams M.D.
(Date and stamp of Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1944, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1944 to 7-22 1944, and that I last saw him alive on 7-22 1944.

Immediate cause of death	Duration
respiratory paralysis	
Due to: staph. septicemia +	
" meningitis +	
Due to: multiple staph. abscesses of lungs.	
Other Conditions + jaundice.	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: (See above.)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas R. Chaffee M. D.
Address Union Mem. Hosp. Date signed 7-22-44

G19253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19253 163 D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Ramona ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Seitz

3 (b) If veteran, name war –

3 (c) Social Security Account No. 212-07-6094

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 - 1873

8. AGE: Years	Months	Days	If less than one day
71	5	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business Bro - Electric Co.

FATHER
12. Name Jacob Seitz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Fannie Seitz
(b) Address 3322 Ramona ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 120 St Paul St

19 (a) Date received by Registrar JUL 25 1944 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24-1944, at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Poisoning

Due to Barbiturate: Aluminal.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-24-44 at 48 hours M.
(b) Where did injury occur? 3322 Ramona ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 94 grains - ingestion

23. Signature Howard J. Weidein M.D.
Medical Examiner.

Date signed 7-26-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19254

19254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

462 Registered No. G19254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4300 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Arabia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA T SCOGGINS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Edwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 16, 1885

8. AGE: Years: 59 | Months: 2 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Warren, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER: 12. Name: William Keys
13. Birthplace: Maryland

MOTHER: 14. Maiden Name: C. Elizabeth Hepburn
15. Birthplace: Maryland

16 (a) Informant: Dorothy N. Wolf
(b) Address: 4300 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)
(c) Cemetery or crematory: Mouland Park
Location: Baltimore Co. Md.

18 (a) Funeral director: Fillmore Gorsuch Inc.
(b) Address: 1219 E. Fort Ave.

19 (a) (Date received) (b) Registrar: Huntington Williams, M.D.

JUL 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 44 to July 22 19 44, and that I last saw h[illegible] alive on July 22 19 44.

Immediate cause of death: Myocardial Failure — Duration: 3 wks
Due to: Hemiplegia — 6 wks
Due to: Carcinoma Sigmoid — 3 yrs

Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: George S Bayley, M.D.
Residence: 32 E Biddle St
Date signed: 7/24/44

G19255

G19255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G19255 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Indiana Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Indiana Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maude C. Williams

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clinton
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1881

8. AGE: Years 62 | Months 8 | Days 16 | If less than one day: hr. min.

9. Birthplace: Point of Rocks, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Hanson Carter
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rachael (unknown)
15. Birthplace: Maryland

16 (a) Informant: Mr. Jesse B. Grimm Sr.
(b) Address: 305 Furrow Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc.,
(b) Address: 1217 St. Paul Street

JUL 25 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to July 23 1944 and that I last saw h[illegible] alive on July 22 1944.

Immediate cause of death: Cardiac Failure — Duration: 3 Months

Due to:

Due to: Myocardial Degeneration

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Paul Schofield
Address: 250 [illegible] Date signed: 7/24/44

G19256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19256

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Haleyon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Haleyon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A Koontz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 18 1852

8. AGE: Years 92 | Months | Days 5 | If less than one day hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business:

FATHER: 12. Name: Jacob Koontz
13. Birthplace: Germany

MOTHER: 14. Maiden Name: Anna Swadow
15. Birthplace: Germany

16 (a) Informant: Lucy Gerry
(b) Address: 2707 Haleyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (Month) (day) (year)

(c) Cemetery or crematory: Baltimore
Location: Baltimore Md

18 (a) Funeral director: Wilbert Lord Dr
(b) Address: 2114 Pont St

19 (a) Date received (Month) (day) (year) JUL 25 1944 (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 23 1944 and that I last saw h[illegible] alive on July 23 1944

Immediate cause of death: Coronary Thrombosis — Duration 7/24/44

Due to Ch Myocard. D.S — 1936

Due to Arterio Sclerosis — 1937

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A Goans M. D.

Address 84 N Kenwood Ave Date signed 7/24/44

G19257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G19257

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Webb Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie L. Egts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or ~~wife~~: Edward Egts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1878

8. AGE: Years 65 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace E. of Liverpool, Ohio
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name George Danigan
13. Birthplace Unknown

MOTHER
14. Maiden Name Lydia "
15. Birthplace "

16 (a) Informant Laura Horne
(b) Address 505 Scott St

17 (a) Burial (b) Date thereof 7/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) (b) Huntington Williams, M.D.
Registrar

FILED JUL 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23rd 1944, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to July 23 1944 and that I last saw ~~him~~ her alive on July 23 1944

Immediate cause of death	Duration
Acute dilatation of Heart	10 da
Due to Cerebral Hemorrhage	6 da.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. L. Campbell M. D.
Address 16 W Hamilton St Date signed 7/24/44

G19258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 94a

Registered No. G19258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (~~years, months,~~ days) 2
(e) Length of stay in Baltimore (~~years, months,~~ days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne
(c) City or town Stevensville 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Oscar Johnson

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Johnson

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 29, 1877

8. AGE: Years 67 | Months 2 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Ill. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Olof Johnson
13. Birthplace Sweeden

MOTHER
14. Maiden Name Christine Peters
15. Birthplace Sweeden

16 (a) Informant Minnie Johnson
(b) Address Stevensville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25, 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Phila. Penna.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

JUL 25 1944 (Date received) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24 1944, at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944, to 7-24 1944, and that I last saw him alive on 7-24 1944.

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Dalyon M. D.
Address University Hosp. Date signed 7-24

G19259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 36 ✓

G19259 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Owings Mills, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years.

3 (a) FULL NAME Robert Tiedemann Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race white | 6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10 1932

8. AGE: Years 12 | Months 5 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Owen's Mills, Md. (Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER 12. Name Robert O. Tiedemann

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Trussler

MOTHER 15. Birthplace Frederick Co.

16 (a) Informant Robert A. Tiedemann

(b) Address Owings Mills

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 25 1944 (month) (day) (year)

(c) Cemetery or crematory Friends Creek Church of God

Location Frederick Co.

18 (a) Funeral director J. F. Elsner & Sons

(b) Address Reisterstown Md.

JUL 25 1944 (Date received) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944, at 7.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1944 to 7-24 1944 and that I last saw h. in alive on 7-24 1944

Immediate cause of death Poliomyelitis Bulbar type — Duration

Due to Resp failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. D. Kaplan, M.D.
Address Reisterstown, Md. Date signed 7-24-44 M. D.

VS 3

G19260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No. G19260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1067 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME GARDNER HORSEY

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Infant
6 (b) Name of husband or wife: Infant
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 9, 1944
8. AGE: Years ... Months 1 Days 14 13 If less than one day ... hr. ... min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation ...
11. Industry or business Infant

FATHER
12. Name Clarence Horsey
13. Birthplace Balto Md

MOTHER
14. Maiden Name Carrie Smith
15. Birthplace Balto Md.

16 (a) Informant Carrie Smith
(b) Address 1067 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Mt Zion Cem.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

JUL 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 1944 at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1944 to 7/22 1944 and that I last saw h[illegible] alive on 7/22 1944.

Immediate cause of death: Dehydration — Duration: ...
Due to: Prematurity & disorder — Duration: ...
Due to: ... — Duration: ...
Other Conditions: ... — Duration: ...

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature A. Robert Marks M. D.
Address Univ. Hosp. Date signed 7/24/44

A. Robert Marks

G19261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Pine
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Pine
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Corbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife James Corbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Willis
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie
15. Birthplace Md.

16 (a) Informant Jamie Corbin
(b) Address 2224 N. Pine St.

17 (a) Burial (b) Date thereof July 25, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Auburn Cem.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3227 N. Schroeder St.

19 (a) (b)
(Date Rec'd by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 44 at 6:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 19 44 to July 22 19 44, and that I last saw h[illegible] alive on July 22 19 44.

Immediate cause of death: Cardiac Insufficiency — Duration 2 dy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7-23-44

G19262

TULIA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19262 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County Winston
(c) City or town Winston (If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Wiggins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife J. W. Wiggins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Talen Moore
13. Birthplace N.C.

MOTHER
14. Maiden Name Dan Jordan
15. Birthplace N.C. Melton

16 (a) Informant Alice Melton
(b) Address 1104 Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)

(c) Cemetery or crematory
Location Alexander N.C.

18 (a) Funeral director Chas. H. Alexander
(b) Address 901 N. Monmouth Huntington Williamson, W.Va.

JUL 25 1944 (Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1945 to 7/24 1945, and that I last saw h[illegible] alive on 7/27 1945.

Immediate cause of death: Carcinoma of Colon Metastasis — Duration 6 mos.
Due to Cardiac Renal Disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T. V. Jackson M.D.
Address 620 Huntington Blvd Tulia

G19263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G19263

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Leona Briggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1911

8. AGE: Years 32 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Neal Reynolds
13. Birthplace Georgia

MOTHER
14. Maiden Name Emma Martin
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary A. A. Co. Md.
Location

18 (a) Funeral director Chas. H. Alexander
(b) Address 947 N. Mount St

JUL 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1944, at 5:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1944, to July 24, 1944, and that I last saw her alive on July 24, 1944.

Immediate cause of death: Pulmonary Tuberculosis with hemorrage

Due to

Due to

Other Conditions: heart disease, etiology unknown (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. D. Davis, Jr. M. D.
Address City Hosp. Date signed 7-24

G19264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 149B

G19264 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Cold Spring Lane (If rural give location)
(e) If foreign born, how long in U. S. A.? 23 years

3 (a) **FULL NAME** Elaine Yetta Hellman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1911

8. AGE: Years	Months	Days	If less than one day
32	8	29	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Samuel Rubach
13. Birthplace Russia

MOTHER
14. Maiden Name Pessie Katz
15. Birthplace Russia

16 (a) Informant Husband
(b) Address 2502 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-44 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Rd

18 (a) Funeral director Jack Levy Inc
(b) Address 1435 E. Baltimore St. Thursday or Hillsdale, Md.

19 (a) JUL 25 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 1:29 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/23/44 19 to 7/25/44 19, and that I last saw her alive on 7/25/44 19.

Immediate cause of death Post Operative Shock — Duration

Due to Caesarean Section

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Sluck, M.D.
Address 2562 Cold Spring Lane, M. D. Date signed 7/25/44

19265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19265

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside Baltimore write RURAL and give town)
(d) Street No. 5005 Kenyon Oak Ave (If RURAL give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Gilbert Elberta

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-9439

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mabel T. Gilbert

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 11, 1879

8. AGE: Years 65 Months 2 Days 12 Or if less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name George E. Gilbert
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Sarah Sipe
15. Birthplace Balto. Md.

16 (a) Informant Mabel T. Gilbert
(b) Address 5005 Kenyon Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/1944 (mo.) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Harry H. Umansky
(b) Address 4204 Ridgewood Ave

(a) JUL 25 1944 (Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23 19 44 at 7 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 19 44 to 7/23 19 44 and that I last saw h[illegible] alive on 7/23 19 44

Immediate cause of death Coronary thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: Coronary occlusion

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.

Address Md. Gen. Hosp. Date signed 7/24/44

G19266

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G19266 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2677 Frederick Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 20
(e) Length of stay in Baltimore (yrs., mos., or days) Forever

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2677 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H Miller Jr

3 (b) If veteran, name war —
3 (c) Social Security Account No. 714-05-6847

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 8th 1881

8. AGE: Years 63 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Insurance Agency Efficient

FATHER
12. Name Joseph H. Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanora Lilly
15. Birthplace Maryland

16 (a) Informant Eleanora Miller
(b) Address 2677 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore and

18 (a) Funeral director Geo. P. Pilspert Son
(b) Address 150 N. Eutaw St.

19 (a) JUL 25 1944 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to July 22 1944, and that I last saw him alive on July 21 1944.

Immediate cause of death Myocarditis
Due to Chr. Interstit Nephritis
Due to
Other Conditions Coronary Thrombosis

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. C. Nibert M. D.
Address 2751 Wilkens Ave Date signed 7/24/44

VS 150

619267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 619267

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1434 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wise
13. Birthplace Va

MOTHER
14. Maiden Name Maggie ?
15. Birthplace

16 (a) Informant Alice Matthews
(b) Address 1434 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-44 (month) (day) (year)
(c) Cemetery Mt Calvary Cemetery
Location Balto Co Md

18 (a) Funeral director Robert Veach
(b) Address 875 Mt Holly Ave Huntington Williams, Md

JUL 25 1944 (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944 at 3:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 12 1944 to July 24 1944, and that I last saw [illegible] alive on July 24 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 9 da.

Due to

Due to

Other Conditions: Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mavin Odom, M. D.
Address 312 E 23rd St Date signed 7-25-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G19268

AB-81925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G19268 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yrs-1mos. 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene Grayson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Henry (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?- 1891

8. AGE: Years	Months	Days	If less than one day
55	?	?	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Robert Jones
13. Birthplace Va.
14. Maiden Name Lucy ?
15. Birthplace Virginia

16 (a) Informant Baltimore/ City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location
18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave
19 (a) JUL 25 1944 (Date received by Registrar) (b) Huntingtown Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21- 1944, at 8.15pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8/43 19 , to 7/21/1944 19 , and that I last saw her alive on 7/21/44 19 .

Immediate cause of death	Duration
Cerebro-vascular Dis	?
Due to H.C.V.D.	?
Due to Chronic Interstitial Nephritis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Balt City Hosp Date signed 7/24/44

G19269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G19269

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Schaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 | 19 | 1863

8. AGE: Years	Months	Days	If less than one day
80	9	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Finn
13. Birthplace Ireland

MOTHER
14. Maiden Name Abigail
15. Birthplace Ireland

16 (a) Informant Mrs. John T. Schaum (Son)
(b) Address 1609 N. Bond St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Edmondson Ave.

18 (a) Funeral director George D. Ruth, Inc.
(b) Address 1795 Harlem Ave. Baltimore, Md.

19 (a) (Date received by Registrar) (b) 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1944 at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriasclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Dated 7/24/44

G19270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G19270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Walter Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1909

8. AGE: Years	Months	Days	If less than one day
35	3	3	hr. min.

9. Birthplace Cumberland Md. (Town, county and state)
10. Usual Occupation Mach. Oper.
11. Industry or business

FATHER
12. Name George Jackson
13. Birthplace Cumberland Md

MOTHER
14. Maiden Name Josephine Brown
15. Birthplace Cumberland Md.

16 (a) Informant Grace Thompson
(b) Address 1610 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1313 Presstman St

19 7 25 1944 (Date received by Registrar) (b) Huntington Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-44 19, at 5.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23-44 19 to 7-23-44 19, and that I last saw h.i.m alive on 7-23-44.

Immediate cause of death Cardiac Failure — Duration
Due to Luetic C.V. disease
Due to
Other Conditions Aortic insuff. Mitral insuff.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury
23. Signature E. Hanton Peil, Jr. M.D.
Address Elmira Hosp Date signed 7-24-44

VS 150

G19271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V92B

Registered No. G19271

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ST
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DOROTHY MAUDE ROBINS

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Augustine J. Robins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/10/1895

8. AGE: Years	Months	Days	If less than one day
48	10	14	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Cannon
13. Birthplace England

MOTHER
14. Maiden Name Matilda ?
15. Birthplace England

16 (a) Informant Mr. Augustine J. Robins
(b) Address 2110 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date received) JUL 25 1944 (By) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1944, at 9.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944, to July 24 1944 and that I last saw her alive on July 24 1944

Immediate cause of death	Duration
Mitral Insufficiency	?
Due to Hypostatic Pneumonia	3 days
Due to Prob. Encephalitis	8 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan D. Burbert M. D.
Address 1803 Park Heights Ave Date signed 7/25/44

G19272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 518

G19272

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 McKean Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 McKean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nolan R. Leppo

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-10-8647

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4, 1884

8. AGE: Years 59 | Months 9 | Days 19 | If less than one day: hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Welsch Const. Co.

FATHER
12. Name Jefferson Leppo
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Minnie Picket
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Nellie L. Leppo
(b) Address 1717 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN CEM.
Location WOODLAWN, MD.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) JUL 25 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1944, at 10:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to July 23 1944, and that I last saw h[illegible] alive on July 21 1944

Immediate cause of death: Cardiac asthma — Duration: 2 da

Due to: Carcinoma of prostate, Bladder — 1 yr

Due to: " " Stone — [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl W. Koons

Address 8064 Smith Ave Date signed July 24/44 D.

Earl W. Koons

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

19273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G19273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Snowden

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-7663

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Selma

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1901

8. AGE: Years	Months	Days	If less than one day
42	9 10	7 8	hr. min

9. Birthplace Monrovia Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Monrovia Md

FATHER
12. Name Harry Snowden
13. Birthplace

MOTHER
14. Maiden Name Ruth E. Boquil
15. Birthplace Md

16 (a) Informant Selma Snowden
(b) Address 1214 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)

(c) Cemetery or crematory Fountain Hills
Location Frederick Co

18 (a) Funeral director Harry E. Cooley Co
(b) Address Frederick, Md.

JUL 25 1944 (b) Huntington Hill (Registrar) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944 at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1944 to July 25 1944 and that I last saw him alive on July 23 1944

Immediate cause of death	Duration
Pulmonary Tuberculosis	18 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 534 Dolfield Blvd signed 7-27-44

19274 X G19274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 928

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route # 4
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Katherine Blanche Morelock

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Richard Morelock

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) March 23, 1911

8. AGE: Years 33 | Months 4 | Days 2 | If less than one day hr. — min.

9. Birthplace Cheryl County, Md.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Harry Miller
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Blanche Blizzert
15. Birthplace Carroll Co. Md.

16 (a) Informant Mr. Richard Morelock
(b) Address Westminster Rt 4 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 25 44 (month) (day) (year)

(c) Cemetery or crematory Meadow Branch Cem.
Location Westminster Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

19 (a) JUL 25 1944 (Registrar's Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1944 to July 25 1944, and that I last saw her alive on July 25 1944.

Immediate cause of death	Duration
Respiratory failure	—
Due to Congestive Heart Failure	Sev. days
Due to Mitral Stenosis	7
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Cook Jr. M.D.
Address Mercy Hospital Date signed July 25 1944

G19275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19275 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 Edythe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Edythe (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Beatrice Bradley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30 1896

8. AGE: Years 48 | Months 2 | Days 22 | If less than one day 11 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Simms
13. Birthplace

MOTHER: 14. Maiden Name Ellen Davis
15. Birthplace West River Md

16 (a) Informant Annetta C. McAllister
(b) Address 1234 Edythe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 26 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md

18 (a) Funeral director A. Hale & Co
(b) Address 918 Druid Hill Ave

JUL 25 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 44 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 19 44 to July 22 19 44, and that I last saw h[illegible] alive on July 21 19 44

Immediate cause of death: Carcinoma of Lt. breast with lung metastases — Duration: 14 mths
Due to
Due to hypostatic pneumonia — 8 days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma Lt. breast.
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. MacMurchy M. D.
Address 1716 Normal Ave Date signed 7/24/44

G19276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G19276
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Robinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10 1917

8. AGE: Years 26 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Winsborough, S. C.
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Robinson
13. Birthplace S. C.

MOTHER
14. Maiden Name Henrietta Pickett
15. Birthplace S. C.

16 (a) Informant Mickele Richardson
(b) Address 765 Hartmer St.

17 (a) Burial (b) Date thereof 7 | 26 | 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Cedar Hill Md

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Washington Funeral Directors Assn

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-1944, at 11:40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Gun shot of Head & lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-21-44 at 11 P. M.
(b) Where did injury occur? 1101 Etting Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire-arm

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 7-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G19277 Registered No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 8 26
(e) Length of stay in Baltimore (yrs., mos., or days) 11 8 26

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town Elizabeth (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Elizabeth's Hospital (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Olive Hopkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1878

8. AGE: Years	Months	Days	If less than one day
65	11	19	hr. min.

9. Birthplace Jersey City, New Jersey (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

MOTHER / FATHER
12. Name Thomas Hopkins
13. Birthplace Ireland
14. Maiden Name Mary Cummings
15. Birthplace Baltimore

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore - 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-44 (month) (day) (year)
(c) Cemetery or crematory Convent Cemetery
Location Convent (near Morristown), N. J.

18 (a) Funeral director Sullivan Mortuary Co.
(b) Address 108 W. North Ave.

19 (a) Date received [illegible] Registrar [illegible] Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 24, 1944, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1932 to July 24 1944, and that I last saw her alive on July 24, 1944.

Immediate cause of death	Duration
Carcinoma of right breast	8 mos.
Carcinomatosis	
Due to	
Due to	
Other Conditions Involutional Melancholia (Include pregnancy within 3 months of death)	11 yrs.

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible]

G19278 CERTIFICATE CORRECTED 2-7-56 G19278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Ward (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5424 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GIOVANNA (Jennie) Maranto

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, (married), widowed, or divorced.
6 (b) Name of husband or wife: SALVATORE (Samuel)
6 (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) 2-28-1894

8. AGE: Years 45 Months 4 Days 25 If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name (BENEDETTO) Di Fatta
13. Birthplace Italy

MOTHER
14. Maiden Name SALVATORA Cammino
15. Birthplace SALVATORE Italy

16 (a) Informant (Samuel) Maranto Husband
(b) Address 5424 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Leonard J. Reyle
(b) Address 5305 Harford Rd

19 JUL 25 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23- 1944, at 7:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 13-00
(a) Date of injury 7-23- at 6.35 P M.
(b) Where did injury occur? Back R. Wildwood Beach Back River
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Boat capsized

23. Signature Howard J. Mudeseis M.D.
Medical Examiner.
Date signed 7-24-44

G19279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19279 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5424 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel F. Marento Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) (Single) married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 10, 1941

8. AGE: Years 3 | Months 6 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Child at Home

11. Industry or business

FATHER
12. Name Samuel Marento Sr.
13. Birthplace Italy

MOTHER
14. Maiden Name Jennie Sutalla
15. Birthplace Md

16 (a) Informant Samuel Marento Jr.
(b) Address 5424 Harford R

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Leonard Rupp
(b) Address 1305 Harford Rd

19 JUL 25 1944 (Date rec'd by local registrar) Hunter for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-1944 at 7-10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-23- at 6.35 P M. (3-00)
(b) Where did injury occur? Patapsco Co. Millwood Branch - Back River
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
(d) Means of injury Boat capsized

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 7-24-44

G19280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146a

G19280 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 W. Fairmount ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 W. Fairmount ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joseph Green.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-1885.

8. AGE: Years 59 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Basil Green
13. Birthplace Md

MOTHER
14. Maiden Name Annie ?
15. Birthplace ?

16 (a) Informant Mary Green
(b) Address 532 W. Fairmount ave

17 (a) Burial (b) Date thereof 7-26-44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

JUL 25 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23rd 1944 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1944 to July 23 1944 and that I last saw him alive on 7-23-44

	Duration
I. Immediate cause of death Carcinoma of Pharynx & Esophagus.	2 mo.
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation? —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature J. T. Guyton M. D.
Address 532 N. Arlington ave Date signed 7-26-44

G19281 A36341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √13B

G19281 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 Heaver St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carmelita Ineader Mickens
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: child
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/12/43

8. AGE: Years | Months: 7 8 | Days: 12 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph M. Mickens
13. Birthplace N.C.

MOTHER 14. Maiden Name Nannie Morris
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Hartstead
(b) Address 718 Reid Hill Ave

19 JUL 25 1944 (b) Huntington Williamsport Md

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944 at 9 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to July 24 1944 and that I last saw her alive on July 24 1944.

Immediate cause of death: The meningitis — Duration: 4 months
Due to
Due to
Other Conditions tbc pulmonary
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Konig M. D.
Address John Hopkins Hosp Date signed 7-25-44

G19282 Richard Beier

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gaten & Wilkens
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Johnnycake Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Beier

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Frances N. Beier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1880

8. AGE: Years 64 Months 1 Days 22 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Grocery man
11. Industry or business Self

FATHER
12. Name Julius Beier
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Frances N. Beier
(b) Address Ingleside Ave. & Johnnycake Rd Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto County Md.

18 (a) Funeral director George V. Schwab
(b) Address Frederick Avenue

19 JUL 25 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25/ 1944, at 4:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1944, to 7/25 1944, and that I last saw him alive on 7/25 1944.

Immediate cause of death	Duration
Aneurism	
Due to Senile Gastritis	
Terminal	
Due to Chronic Gastric	
ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M. D.
Address St. Agnes Hosp. Date signed 7/25/44

G19283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

G19283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Key Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.
(c) City or town Baltimore
(If outside city or town limits, write Rural, and give town)
(d) Street No. 1610 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES T. CLARK

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-22-2866

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mandi Clark

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1869

8. AGE: Years 74 | Months 8 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Bullitt Ct. Kentucky
(Town, county, and state)

10. Usual Occupation Electrician Helper

11. Industry or business Running & Co.

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Audrey Barbee
(b) Address 1610 E. Balto. St.

17 (a) Removal (b) Date thereof July 26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ashland
Location Kentucky

18 (a) Funeral director Fred. A. Krause & Son
(b) Address 1214 E. Chase St.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

JUL 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1944, at 11:30 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. T. Williams M.D.
Medical Examiner.
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V128

G19284

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Guem Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Belaire Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta E. Cubbage

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Mr. John Cubbage
Deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-18 70

8. AGE: Years	Months	Days	If less than one day
73	9	—	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation H-W
11. Industry or business

FATHER
12. Name John Keitzer
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Jacobi
15. Birthplace Germany

16 (a) Informant Jack J. Cubbage
(b) Address 4412 Belaire Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Elm Section Taylor Ave.

18 (a) Funeral director Walter Banks Bradley Sons
(b) Address 1922 N. North Ave

19 (Date received) JUL 25 1944 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1944 to July 24 1944, and that I last saw her alive on July 23 1944.

Immediate cause of death	Duration
Pulmonary edema	
Due to Respiratory Collapse	
Due to Acute Pancreatitis	
Other Conditions Cholecystitis	

(Include pregnancy within 3 months of death)
Date of operation July 23, 1944
Major findings of operation: Acute pancreatitis, hemorrhagic
of autopsy: Necrosis of gallbladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature LeRoy W. Tolf Jr.
Address University Hosp. Date signed 7/24/44 (M. D.)

G19285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12-7a

Registered No. G19285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Conowingo Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tidal Road.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella V. Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	white	married

6 (b) Name of husband or wife Eli Rice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1878

8. AGE: Years	Months	Days	If less than one day
66	4	3.	hr. min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Randel Barrow
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name R. Revinger
15. Birthplace Cecil Co. Md.

16 (a) Informant Eli Rice
(b) Address Conowingo, Md.

17 (a) Burial (b) Date thereof July 28 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Grove
Location Lancaster Co. Pa.

18 (a) Funeral director Lee A. Pattison & Son
(b) Address Perryville, Md.

JUL 26 1944 (a) Filed by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25/44 19 at 9:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1944, to 7/25 1944, and that I last saw h.e.r alive on 7/25 1944.

Immediate cause of death	Duration
Congestive heart failure	
Due to P.O. 10 hrs	
Due to Cholecystostomy	
Other Conditions H. C. V. D. (Include pregnancy within 3 months of death)	
Date of operation 7/25/44	
Major findings of operation: Chr. cholecystitis	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Traynor M. D.
Address Md. Genl. Hosp. Date signed 7/25/44

G19286
JL - 74288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

936

G19286
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 1 - 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Nolan

3 (b) If veteran, name war: --None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Caroline Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1879

8. AGE: Years 64 | Months 10 | Days 24 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Doorman

11. Industry or business Stanley Theatre

FATHER
12. Name Patrick Nolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Hardiser
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) JUL 26 1944 Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28 1942, to 7/24 1944, and that I last saw him alive on 7/24 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to HCVD	?
Due to Cerebral Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Nolle M. D.
Address BCH Date signed 7/24/44

G19287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19287 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave.
(c) Hospital or institution:
Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Goldberg

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 1874

8. AGE: Years 70 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Isaac D Kaplan
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 7-26-44 (month) (day) (year)
(c) Cemetery or crematory Wash. Blvd.
Location Wash. Blvd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 JUL 26 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1944, to 7-24 1944, and that I last saw h.L.R. alive on 7-24 1944.

Immediate cause of death	Duration
Carcinoma of R. Breast with local metastasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Lewis
Address Levindale Date signed 7/26/44

(over)

G19288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvidere & Greenspring Ave.
(c) Hospital or institution: Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Levindale
(If outside city or town limits, write name of town)
(d) Street No. Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Aaronson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Lith

MOTHER
14. Maiden Name Mingail
15. Birthplace Lith

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Belmont Ave.

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto St

19 (a) JUL 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 9:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 1941, to 7-25 1944, and that I last saw her alive on 7-25 1944.

Immediate cause of death Arteris Sclerosis | Duration
Hypertension Diabetes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levine M. D.
Address Levindale Date signed 7/28/44

G19289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 V

Registered No. G19289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Haber
15. Birthplace Md.

16 (a) Informant Chas L Bailey
(b) Address 2240 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 26-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 601 E 22nd St

19 (a) JUL 26 1944 (Date received) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24 1944, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1944, to 7/24/1944, and that I last saw h[illegible] alive on 7/24 1944.

Immediate cause of death

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Palluccio M.D.

Address St. Agnes Hosp Date signed 7/26/44

19290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12HA

Registered No. G19290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen'l. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. 29th St. #18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Perl Forney

3 (b) If veteran, name war I

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Kathryn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1892

8. AGE: Years 52 | Months 3 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Keywille Md Md.
(Town, county, and state)

10. Usual Occupation R.R. Track Inc. Engineer

11. Industry or business " " " "

FATHER
12. Name Alfred N. Forney
13. Birthplace Carroll County

MOTHER
14. Maiden Name Philonesia, Cesandra Kelly
15. Birthplace Frederick County

16 (a) Informant Nora E. Forney
(b) Address 871 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Md

18 (a) Funeral director William Cook Inc
(b) Address 15 St. Paul St.

19 JUL 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25/44 1944, at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16/1944, to 7/25/1944, and that I last saw him alive on 7/25/1944.

Immediate cause of death Hepatic Cirhosis — Duration

Due to Lifetime of Heavy Drinking

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers, M. D.

Address 702 Lex. Bldg. Date signed 7/25/44

G19291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13 1a

Registered No. G19291

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Saint St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Saint St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elwood A. Christopher

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Kate
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Oct 20, 1872
8. AGE: Years 71 | Months 9 | Days 5 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town) (county) and state)
10. Usual Occupation Leather Worker
11. Industry or business John Pragel

MOTHER / FATHER
12. Name Oliver P. Christopher
13. Birthplace Baltimore Md
14. Maiden Name Martha Margaret
15. Birthplace Baltimore Md

16 (a) Informant Kate Christopher
(b) Address 423 Saint St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn - Md
18 (a) Funeral director Wm Cook Son
(b) Address Balto Md
JUL 26 1944 (Date rec'd by Registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1944 to July 25 1944 and that I last saw alive on July 25 1944

Immediate cause of death Uremia — 5 Days

Due to Arteri-Sclerotic Nephritis —

Due to Arteriosclerosis —

Other Conditions Senile Decubitus

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis J. Sap M. D.
Address 926 Wilkens Ave Date signed 7/25 1944

G19292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144B

G19292 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 52 - East 26th: St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 17 (GISMARSH-HALL)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits write RURAL and give town)
(d) Street No. 52 - East 26th: St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RUTH ALICE A. SEYFERT.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband Rev. F. C. Seyfert - B.D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1905.

8. AGE: Years	Months	Days	If less than one day
39	1	7	hr. min.

9. Birthplace Maine. (Town, county, and State)
10. Usual Occupation Housewife -
11. Industry or business At home.
12. Name (FATHER) Frank N. Hall.
13. Birthplace Unknown.
14. Maiden Name (MOTHER) Lillyan Sloan.
15. Birthplace Unknown
16 (a) Informant Rev. F. C. Seyfert - B.D.
(b) Address 52 E. 26th: St.
17 (a) Removal. (Burial, cremation, or removal) (b) Date thereof July-26-44 (month) (day) (year)
(c) Cemetery or crematory Northeaston Cemetery
Location Northeaston - Massachusetts
18 (a) Funeral director Charles J. Schwartz.
(b) Address 505 N. Monroe St.
(c) Jul 26 1944 (Date rec'd by registrar) (d) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 25th: 1944 at 10.20 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1944 to 7-24 1944.
and that I last saw h... alive on 7-24 1944.

	Duration
Immediate cause of death Pulmonary Thrombosis.	7 days
Due to Toxemia of Pregnancy -	?
Due to Nephritis - Interstitial -	?
Other Conditions Diabetis -	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. D. Edwards M.D.
Address Medical Arts Bldg. Date signed 7/25/44

VS-150

G19293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

G19293

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 McCulloh St. (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Sewell

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.
4. Sex: M
5. Color or race: B
6 (a) ~~Single, married, widowed~~, or divorced.
6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1898
8. AGE: Years 46 | Months | Days | If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Andrew Sewell
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Chase
15. Birthplace Charles Co. Md.

16 (a) Informant Lily Sewell
(b) Address 1506 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 27 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cemetery
Location Br. Halstead.

18 (a) Funeral director
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUL 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1944, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1944, to July 19, 1944, and that I last saw him alive on July 19, 1944

Immediate cause of death Anemia and emaciation — Duration 4 mo.

Due to Probable Generalized carcinomatosis — Duration 4 mos. or longer

Due to Extensive liver damage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin H. Thompson M. D.
Address University Hospital Date signed 7/26/44

G19294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 C

Registered No. G19294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 Huntington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Whittington

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1944

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Balto; Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Glover C. Whittington
13. Birthplace Carthage, Miss.

MOTHER
14. Maiden Name Carmelita Alberta
15. Birthplace Balto. Md

16 (a) Informant Mrs Carmelita Whittington
(b) Address 2837 Huntington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St

19 (a) JUL 26 1944 Huntington Ave Methodist
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1944, at 3:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 19 44 to 7/25 19 44 and that I last saw h[illegible] alive on 7/25 19 44

Immediate cause of death	Duration
(a) Asphyxia	
Due to (b) Prolonged Labor	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Turner M.D.
Address Mercy Hosp Date signed 7/26/44

C19295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. C19295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 Cornwall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE NEUBERT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1853

8. AGE: Years 90 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name W. Seward
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Neubert (Son)
(b) Address 335 S. Cornwell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St.

18 (a) Funeral director Adam F. Hoffman
(b) Address 1639 N. Broadway

19 (a) JUL 26 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 11 45 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebrovascular
cardiovascular
Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. T. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 7-23-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G19296~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 (over) G19296 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Dobler Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Harry L. Neuman
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Yursik Neuman
6 (c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) 8/18/85

8. AGE: Years 59 yrs. | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Own Business - Tavern

11. Industry or business

FATHER 12. Name Emil Neuman
13. Birthplace unknown

MOTHER 14. Maiden Name Blaha
15. Birthplace unknown

16 (a) Informant wife
(b) Address 2107 Dobler Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or ~~xxxx~~ Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 JUL 26 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944 at 7 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944 to 7-24 1944 and that I last saw him alive on 7-23 1944.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic Cardio-Vascular disease.

Due to

Other Conditions Pneumonia (base of both lungs).
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 7-24-44

G19297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

G19297 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edmond
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/1926

8. AGE: Years 18 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Tillery N. C. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Edmond
13. Birthplace N.C

MOTHER
14. Maiden Name Irene Bullet
15. Birthplace NC

16 (a) Informant Robert Edmond
(b) Address 1319 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.Q. Co

18 (a) Funeral director Rayner Saunders
(b) Address 1412 E. Preston St

(a) 7-6-1944 (Date received by registrar) (b) Huntington Williams

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-1944 to 7-22 1944 and that I last saw him alive on 7-22 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 4 mos 22 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Edmond
Address 1422 E. Chase Date signed 7-26-44

G19298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No. G19298

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 918 BURGUNDY. ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 BURGUNDY. ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA JAMES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife WM. GEO JAMES

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) DEC. 25-1871

8. AGE: Years 72 | Months 7 | Days | If less than one day hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation HOUSEWORK.

11. Industry or business AT HOME

FATHER 12. Name CONRAD BLOCKINGER.

13. Birthplace PA

MOTHER 14. Maiden Name CAROLINE BEARCARDINER

15. Birthplace PA

16 (a) Informant CHAS T. PRINCE

(b) Address 2823 INDIANA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 29-44 (month) (day) (year)

(c) Cemetery or crematory SCHWARTZ CEM

Location BALTO MD

18 (a) Funeral director Bernard C Hasle

(b) Address 121 E Preston St

JUL 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at M

21, I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 25 1944, and that I last saw her alive on July 25 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 week.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schwartz

Address 320 Armistead Date signed 7/25/44

VS 160

G19299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167 Registered No. G19299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN W. ROBINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Married

6 (b) Name of husband or wife Alice M.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 8, 1902

8. AGE: Years	Months	Days	If less than one day
41	7	16	hr. min.

9. Birthplace Gloucester, Va. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business
FATHER 12. Name Jos. H. Robinson
13. Birthplace Gloucester, Va.
MOTHER 14. Maiden Name Harriett Hillis
15. Birthplace Gloucester, Va.
16 (a) Informant Alice M. Robinson
(b) Address 2501 Madison Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Location Gloucester, Va.
18 (a) Funeral director Wm. George H. Holland
(b) Address 1631 Druid Hill Ave, Huntington Williams, Md.
19 (a) (Date received by local registrar) JUL 26 1944 Registrar

S 161

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944, at 3 25 P.M.
21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH Stab wound of chest
Due to
Other Conditions
(Include pregnancy within 3 months of death)
22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8:15 A.M. 7-23-44
(b) Where did injury occur? 2412 Madison Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Stabbed during altercation
23. Signature H. L. Wellenbarber M.D. Medical Examiner.
Date signed 7-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLASAJ

619300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1102

Registered No. 619300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway and Fairmount Ave

(c) Hospital or institution:

Church Home and Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 822 S. Rappolo Street
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country Roppolla

3 (a) FULL NAME Plasaj, Stephen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1921

8. AGE: Years	Months	Days	If less than one day
22 yrs.	11 mos.	15	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER | FATHER

12. Name Plasaj, Stephen

13. Birthplace Yugoslavia

14. Maiden Name Benthovil, Ellen

15. Birthplace Yugoslavia

16 (a) Informant STEPHEN PLASAJ (FATHER)

(b) Address 822 S. RAPPOLA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-29-44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ SACRED HEART

Location GERMAN HILL RD. BALTO. CO.

18 (a) Funeral director Charles S. Zeiler

(b) Address 3605 Fait ave.

19 (a) Filed (Date received by Registrar) JUL 26 1944 (b) Address Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1944 to 7-26 1944, and that I last saw him alive on 7-26 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cardiac Failure	
Due to Chronic Empyema, Right	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-19-44

Major findings of operation: Long Sinus Tract in old Thoracoplasty scar. (OK)

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert D Daly M. D.

Address Date signed 7-26-44

G19301 Sherman

HEALTH DEPARTMENT—CITY OF BALTIMORE

G19301

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2177 Pine St. Ward) 4-2131a

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in City or town where death occurred 30 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Sherman Wilson

(a) Residence: No. 2177 Pine St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Wilson

6. DATE OF BIRTH (month, day, year) March 6 1890

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 7 '44

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) U.S.

FATHER

13. NAME I do not Know

14. BIRTHPLACE (city or town) (State or country) ?

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Lizzie Semple

(Address) 2177 Pine St.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Date 7-27- 19 44

19. UNDERTAKER Wm. Neal & R. W. Williams

(Address) 322 N. Fulmore St.

20. FILED JUL 26 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 24, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1944 to July 24, 1944

I last saw him alive on July 23 1944 and death is said to have occurred on the date stated above, at 8:30 a.m. p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Renal complications	" "

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) J. B. Stewart M. D.

(Address) 632 W. Fayette St.

MAKE CAUSE OF DEATH in plain terms, so that neither it nor OCCUPATION is very important. See instructions on back of certificate.

G19302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

Registered No. G19302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 195 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 195 S. Aisquith St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Harrington
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Fe
5. Color or race C
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife James Hunter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1901
8. AGE: Years 43 Months Days If less than one day hr. min.
9. Birthplace Waynesboro, N C (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Alexander Harrington
13. Birthplace Charlotte, N. C.

MOTHER
14. Maiden Name Bessie Means
15. Birthplace N. C.

16 (a) Informant Jane Chavers
(b) Address 195 S. Aisquith St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Lakeland
18 (a) Funeral director Mrs. Katie Williams
(b) Address 322 N. Aisquith St
19 (a) (Registrar's signature) (b) Huntington Williams M.D.
JUL 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944, at 6:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to July 23 1944 and that I last saw deceased alive on July 23 1944

Immediate cause of death	Duration
Meningo-Vascular Syph	9 months
Due to Syph	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Reagan W. Perkins M.D.
Address 426 N. Gilmor Signed 7/27/44

VS 100

G19303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 176

G19303 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 5.5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Poplar street
(If rural give location)
(e) Citizen of foreign country? Poplar (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Rosenthal

3 (b) If veteran, name war

3 (c) Social Security Account No. 156-05-1679

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nettie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Jersey City, N. J. (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Beth.-Fairfield Shipyards

FATHER
12. Name William Rosenthal
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Nettie Rosenthal
(b) Address 1619 Poplar St

17 (a) Burial (b) Date thereof 7-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Removal
Location Jersey City N. J.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) 1944 (b)
(Date rec'd by registrar) Registrar

YS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 8:7 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Multiple Fractures

Other Conditions Laceration, abrasions & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/25/44 at 3:15 P.M. 25/6
(b) Where did injury occur? Bethlehem Fairfield Shipyards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Slipped on plug + fell down hatch Ground

23. Signature Thomas J. Medairy M.D.
Medical Examiner.
Date signed 7-26-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G19304
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Clautice
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Baltimore

18 (a) Funeral director Rita Winefield
(b) Address 914 Commonwealth Ave

19 (a) Date received by registrar Huntington Williams, M.D.
JUL 26 1944

VS 150

MEDICAL CERTIFICATION 3 a.m.

20. DATE OF DEATH July 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1944 to July 24 1944 and that I last saw him alive on

Immediate cause of death	Duration
Cerebral hemorrhage	7 days
Due to General arteriosclerosis	
Due to	
Other Conditions Heart & Kidneys	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: X X X X
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence X X X X at M
(c) Where did injury occur? X X X X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? X X X X (Specify type of place)
(e) Means of injury

23. Signature Otto H. Duker M.D.
Address 928 E. North Ave Date signed 7/26/44 M. D.

G19305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G19305 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Accuracy is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St

(c) Hospital or institution: Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Nellie Guard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or ~~wife~~ Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Peter Doyle

13. Birthplace Ireland

MOTHER 14. Maiden Name Rose Mitchell

15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St.

17 (a) Burial (b) Date thereof July 27, 1944 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

19 (a) (b) Huntington Williams M.D.

(Date rec'd by registrar) JUL 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944, at 5 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to 7/24 1944, and that I last saw h alive on 19

Immediate cause of death Terminal Tachycardia. Duration 7 days

Due to Chr Nephritis

Due to Chr Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: XXXX

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide none

(b) Date of occurrence XXXX M

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? XXXX (Specify type of place) While at work?

(e) Means of injury

23. Signature Otto H. Dupkermann M.D.

Address 928 E. North Date signed 7/26/44

G19306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G19306 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Hinkleman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ann T.
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 16 1884

8. AGE: Years 60 | Months - | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business Balto. City

FATHER
12. Name George Hinkleman
13. Birthplace Balto

MOTHER
14. Maiden Name Catherine McQuade
15. Birthplace Balto

16 (a) Informant Wife
(b) Address 2004 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director M. W. Kipp's Sons
(b) Address Lombard & Ann Sts.

JUL 26 1944 (Date rec'd by Registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26 1944, at 5.30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. Kendall M.D. Medical Examiner.
Date signed 7/28/44

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

184253

G19307

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1270

G19307
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Abingdon
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Saunders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1881

8. AGE: Years	Months	Days	If less than one day
63	-	-	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House Keeper
11. Industry or business

FATHER 12. Name Thomas Saunders
13. Birthplace Va.

MOTHER 14. Maiden Name Sarah Snow
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 1944 (month) (day) (year)
(c) Cemetery or crematory John Wesley
Location Abingdon Md

18 (a) Funeral director Howard K. McComas
(b) Address Abingdon Md

19 (a) 7-26-1944 (Date received by registrar) Huntington Williams M.D.

SOL 26 Cvs 156

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944 to July 22 1944 and that I last saw her alive on July 22 1944

Immediate cause of death	Duration
Aspiration of gastric contents	
Due to Empyema of Gallbladder	2 wks.
Ascites.	
Due to	
Other Conditions Arteriosclerotic Heart disease, Cerebral accident (Include pregnancy within three months of death)	

Date of operation 7/21/44 - Chalmers Eckley
Major findings of operation Empyema of Gall bladder
of autopsy: Aspiration gastric contents

PHYSICIAN — Underline the one to whom death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M. D.
Address J. H. H. Date signed 7-23-44

G19308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$38

G19308
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 N. Caroline St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles O. Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife S. Almira Coleman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 4, 1861

8. AGE: Years	Months	Days	If less than one day
83	5	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired - Bay Pilot
11. Industry or business

FATHER
12. Name Samuel O. Coleman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maachah Corprew
15. Birthplace Virginia

16 (a) Informant Miss Almira Coleman
(b) Address 1411 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27,1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Wells Lawrence
(b) Address 4510 Liberty Heights Ave.

(a) (Registrar) (b) Huntington Mills, Md.

JUL 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 8. 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 July 24 1944 and that I last saw h. im alive on July 24 1944

Immediate cause of death: Cerebral Thrombosis — Duration

Due to Arteriosclerosis — 5 yrs

Due to Low Blood pressure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. O. Mills M. D.
Address 3136 Harford Ave. Date signed

G19309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 1902 Boone Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Boone Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE C.HOUCHENS

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Dr. John T. Houchens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas Moore
13. Birthplace ~~Baltimore~~ Richmond, Va.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Mildred Bellman
(b) Address 4408 Adelle Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Lipsitz Funeral Home
(b) Address 1500 Park Ave.

19 JUL 27 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1944 to July 25 1944 and that I last saw her alive on July 25, 1944

	Duration
Immediate cause of death: Coronary thrombosis	2 days
Due to: Arteriosclerosis	1 yr.
Due to:	
Other Conditions: Diabetes	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert E. Sigwald M.D.
Address 1613 E.North Ave. Date signed 7-26-

G19310 Colson BALTIMORE CITY HEALTH DEPARTMENT X ✓ G19310

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Winfield, Westminster, Md
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Winfield
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Colson, Mr. William

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Mary Colson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-77

8. AGE: Years 67 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Martin Colson
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie Dorsey
15. Birthplace Maryland

16 (a) Informant Mary Colson
(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date then July 29 44
(month) (day) (year)
(c) Cemetery or crematory Woodbine
Location Carroll Co Md

18 (a) Funeral director Hart Unk Sons
(b) Address Manchester Md

19 (a) AUG 27 1944 Huntington for Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 19 44, at 1115 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-1944, to 7-26 1944, and that I last saw h/m alive on 7-26 19 44.

Immediate cause of death
? Cerebral embolism — 7
Old coronary infection — 3
Due to Arteriosclerotic heart disease — 7
Due to —
Other Conditions Multiple pulmonary infarcts
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Gen & Hosp

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lewis Sieg M. D.
Address Church Home & Hosp Date signed 7-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150.

G19311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G19311 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1319 Hanover St.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1319 Hanover St.,
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Richard Neumann

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	220-03-6133

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Louise Neumann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Cabinet maker

11. Industry or business

FATHER
12. Name Don't know
13. Birthplace Don't know

MOTHER
14. Maiden Name Don't know
15. Birthplace Don't know

16 (a) Informant Mr. Morris Rowe

(b) Address 1319 Hanover St.,

17 (a) Burial (b) Date thereof 7/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home,

(b) Address 2008 Orleans St.,

(a) [illegible] (b)

JUL 27 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to July 25 1944 and that I last saw [illegible] alive on July 24 1944

Immediate cause of death

Due to Acute dilatation of heart — Duration 2 Ds.

Due to Mitral regurgitation — Duration July

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. C. Campbell M. D.

Address 1644 Ramsay St. Date signed 7/26/44

19312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

Registered No. 19312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4903 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4903 Harford Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Virginia Rosenthal

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walter Rosenthal
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) May 15 1877

8. AGE: Years 67 | Months 2 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Leo Curtasi
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dora Kusa
15. Birthplace Baltimore

16 (a) Informant Mrs Myrtle Brinkman
(b) Address 4903 Harford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) JUL 27 1944 (b) Huntington Ave, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1944, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944, to July 26 1944, and that I last saw h.e alive on July 26 1944.

Immediate cause of death Acute Myocarditis — Duration 4 Days
Due to Pancarditis
Due to Hypertension & arteriosclerosis
Other Conditions Chronic Arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. V. Harbold M. D.
Address 4706 Harford Rd Date signed 7/26/44

G19313 TORCHIA ✓ G19313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3447 Woodstock Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Torchia

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-0696

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie M Torchia

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1891

8. AGE: Years 52 | Months 10 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Pittsburg Pa (Town, county, and state)

10. Usual Occupation Labor - Foreman

11. Industry or business Amer. Smelting & Ref. Co.

FATHER
12. Name Frank Joseph Torchia
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. Annie Torchia
(b) Address 3447 Woodstock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Milburn Lodge Inc
(b) Address 2170 E Pont St

JUL 27 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24- 1944, at 1:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Acute Congestive Cardiac Failure

Other Conditions Hypertrophy & dilatation of Heart

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulden M.D. Medical Examiner.
Date signed 7-26-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G19314

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 Light st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Light st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Concetta M. Di Pietro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, ~~married~~, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Salvatore Di Pietro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1864

8. AGE: Years 75 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business At home

FATHER
12. Name Vincent Gilio
13. Birthplace Italy

MOTHER
14. Maiden Name Tessa (Unknown)
15. Birthplace Italy

16 (a) Informant Joseph Di Pietro
(b) Address 824 Light st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 120 St. Paul st.

JUL 27 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th 1944, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to July 24 1944 and that I last saw her alive on July 24 1944.

Immediate cause of death: Senility - Myocardial insufficiency — Duration

Due to: Hypostatic pneumonia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed Turley M.D.
Address 1188 Hollins Date signed 7/28/44

G19315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G19315 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkerson and Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Nuessle

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-0365

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Husband

6 (b) Name of husband or wife: Mary Nuessle

6 (c) If wife, give age ——years

7. Birth date of deceased (mo., day, yr.) July 22, 1888

8. AGE: Years 56 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Plumbing & Heating

11. Industry or business Bibbs Heating Co.

FATHER
12. Name Jacob (Dec'd)
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte (Dec'd)
15. Birthplace Maryland

16 (a) Informant Lottie Nuessle
(b) Address 403 S. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director F. B. Tippett & Son
(b) Address 1850 N. Baltimore St

19 JUL 27 1944 (b) Huntington Williamson, M.D.
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24 1944, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1944 to 7/24 1944, and that I last saw h[illegible] alive on 7/24 1944

Immediate cause of death	Duration
Pulmonary Edema	
Due to Heart Failure	
Due to Acute Pancreatitis	
Other Conditions Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation 7/24/44

Major findings of operation: Fat necrosis, Acute Pancreatitis, Cholelithiasis

Findings of autopsy: NECROSIS

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Raffucci M.D.
Address St. Agnes Hosp Date signed

G19316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G19316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave 1525
(c) Hospital or institution: SINAI Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Tioga Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Comings (CUMINGS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Michael Cumings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Harry Caplan

13. Birthplace Russia

14. Maiden Name Mary –

15. Birthplace Russia

16 (a) Informant Mrs. Ella Newman

(b) Address 3038 Tioga Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-44 (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jos. Levin Sons

(b) Address 1398 E. Balto. St

19 (a) JUL 27 1944 (Date registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26 1944 at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1944 to 7/26 1944 and that I last saw h-- alive on 7/20 1944.

Immediate cause of death	Duration
CARCINOMA Head of Pancreas	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Stainberg

Address 3 West Hoffman Date signed 7/26/44

H. S. Stainberg

G19317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G19317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3406 Calloway Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rose Fleishman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel Fleishman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name Abraham Theodas-

13. Birthplace Russia

MOTHER

14. Maiden Name Nadie-

15. Birthplace Russia

16 (a) Informant Mrs Lillian Lee

(b) Address 3406 Calloway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-44 (month) (day) (year)

(c) Cemetery or crematory Mishkan Israel Cem.

Location Northern Ave

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1439 E Balto St

19 7-27-1944 Huntington Woodlawn, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1944 to 7/27 1944 and that I last saw her alive on 7/27 1944

Immediate cause of death Respiratory failure — Duration

Due to Cerebro vascular accident

Due to Hypertensive arterio-sclerotic cardiovasc dis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howard Aksman M. D.

Address Sinai Hosp. Date signed 7/27/44

19318

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 467

G19318

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore 4007 Fleetwood ave
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4007 Fleetwood ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fannie Florence Hyde

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Isaac Clayton Hyde
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) October 15, 1872
8. AGE: Years 65 Months 9 Days 12 If less than one day ..... hrs. ..... min.
9. Birthplace Hagerstown, Washington, Maryland
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name James Dr Braguniers
13. Birthplace Hagerstown, Maryland

MOTHER
14. Maiden name Elizabeth Rose
15. Birthplace Hagerstown, maryland

16. Informant Charles C. Shellmans
Address 4007 Fleetwood ave. Baltimore (6) Md

17. ..... Date thereof ..... (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory Broadfording Cemetery
Location Near Broadfording Md
18. Funeral director Andrew K Hoffman
Address Hagerstown Md.

JL 27 1944 (Date rec'd by Registrar) 19 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1944, to ..... 19..

and that I last saw h.. alive on ..... 19..

Immediate cause of death

(a) Carcenomas of Rectum — DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operation Carcenomas of Rectum Date of op. March 21st 1944

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Walter A Anderson M. D. or other

Address 2001 Shannon Drive Date signed .....

G19319 T.C.P.-89080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G19319

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Mount Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Keating

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie Keating

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1893

8. AGE: Years 50 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Keating (D)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Bacon (D)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1944 (month) (day) (year)
(c) Cemetery or crematory Lakeview Park
Location Baltimore County, Md.

18 (a) Funeral director Joseph G. Healy
(b) Address 1101 W. Mount Street

19 (a) JUL 27 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1944 19 , at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 19 44, to 7/25 19 44, and that I last saw h.im alive on 7/25 19 44

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. C. Perry Jr. M. D.
Address City Hosp. Date signed 7-26

VS 150

G19320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G19320
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M. Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1881

8. AGE: Years 62 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Columbia, Pa. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Harriett Fischer
15. Birthplace Switzerland

16 (a) Informant Mr James Kelly
(b) Address 517 S. Fulton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto.

18 (a) Funeral director Frederick & Cole
(b) Address 1200 W. Lombard St

19 (a) (Date rec'd by registrar) JUL 27 1944 (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1944, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1944, to 7/24 1944 and that I last saw he alive on 7/24 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Diabetes Coma due to Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c). Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M.D.
Address St. Agnes Hosp. Date signed 7/24/44

G19321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1262

G19321 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 W. Franklin St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emma Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Vernon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1925

8. AGE: Years 18 Months 9 Days 21 If less than one day hr. min.

9. Birthplace Ferrell, Ga. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Waverly Mason

13. Birthplace Va

MOTHER 14. Maiden Name Elizabeth Tebb

15. Birthplace Va

16 (a) Informant Elizabeth Edwards

(b) Address 1629 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore Co. Md

18 (a) Funeral director Jno. Geo. W. Holland

(b) Address 1634 Druid Hill Ave.

19 (a) JUL 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 2:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944, to July 24 1944, and that I last saw h. alive on July 24 1944.

Immediate cause of death Septicaemia — Duration 3 Weeks

Due to Staph. hemolyticus

Due to

Other Conditions Pelvic Abscess

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Garfield, M.D.

Address Provident Hospital Date signed July 26 1944

G19322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G19322 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 E. Madison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Avis Tynes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1919

8. AGE: Years	Months	Days	If less than one day
25	5	3	hr. min.

9. Birthplace Smithfield, Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Tynes
13. Birthplace Va

MOTHER
14. Maiden Name Ida Coffee
15. Birthplace Va

16 (a) Informant Nannie Tynes
(b) Address 1733 Ashland Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Elroy O Wilson
(b) Address 1900 Brandon
19 (a) JUL 27 1944 (Date rec'd by registrar) (b) Huntington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25-1944, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myelitis of spinal cord
due to Gunshot
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-26-43 at ? M.
(b) Where did injury occur? Central Ave + Jefferson St
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury: Firearm - revolver

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 7-26-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G19323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 119a

Registered No. G19323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. Box 282
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Frisby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1944

8. AGE: Years | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Alfred Frisby.
13. Birthplace Md.

MOTHER
14. Maiden Name Ethel Hunt
15. Birthplace Va.

16 (a) Informant Ethel Frisby
(b) Address RF.D. Box 282 - Dundalk Md.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 JUL 27 1944 (Signature and title) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1944, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1944, to 7-26 1944, and that I last saw him alive on 7-26 1944.

Immediate cause of death	Duration
Acidosis	
Due to Dehydration	
Due to Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Palmason M. D.
Address University Hospital Date signed 7-26

G19324 326575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30c Registered No. G19324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 E Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mildred Barnes
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.): 6-27-18

8. AGE: Years 26 | Months - | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation handyman

11. Industry or business

FATHER
12. Name Gil Barnes
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Barnes
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal (b) Date thereof July 27 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1944 Bradley Ave

19 (a) JUL 27 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 23 1944 and that I last saw him alive on July 23 1944

Immediate cause of death: Unclassified Neuro - syphilis — Duration: ?

Due to: ? Tumor Brain

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Russell G. Nelson M. D.
Address Johns Hopkins Hosp Signed July 23

G19325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Cody V 159

G19325
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 N. Monroe Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Baby Girl Cody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married~~ ~~widowed~~, or ~~divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/44

8. AGE: Years | Months | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Premature baby

11. Industry or business

FATHER
12. Name Fred Cody
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Angela Manna
15. Birthplace Balto. Md.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto, Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date received by registrar) (b) Registrar

JUL 27 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1944 at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13, 1944, to July 25, 1944, and that I last saw h.E.T. alive on July 25, 1944.

Immediate cause of death Respiratory failure — Duration
Due to Prematurity — 12 Days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Deem Pondal, M. D.
Address Univ. Hospital Date signed 7/25/44

G19326 X V G19326

G19326 BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Camp Holabird
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Valencia (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #2 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Capt. Wm R. Maloney U.S.A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife R. S. Maloney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1902

8. AGE: Years	Months	Days	If less than one day
42	-	1	hr. min.

9. Birthplace Wampum, Pa. (Town, county, and state)

10. Usual Occupation Construction Engineer

11. Industry or business

FATHER 12. Name Wm Thomas Maloney

FATHER 13. Birthplace Wampum Pa

MOTHER 14. Maiden Name Laura Bill

MOTHER 15. Birthplace Wampum, Pa

16 (a) Informant U.S.A.

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)

(c) Cemetery or crematory Graceland Cem.

Location New Castle, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)

JUL 27 1944 (Date rec'd by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-1944, at 6:15 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madden M.D. (Medical Examiner.)

Date signed 7-26-44

...age is especially important. Physicians: please write the ...e the causes of death clearly and legibly.

G19327

BALTIMORE CITY HEALTH DEPARTMENT G19327 Registered No.

CERTIFICATE OF DEATH 56E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Jos Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3805 Conduit Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HAHN (JOHN WILLIAM HAHN)

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 213-10-1240

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace E. (Harman)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1889

8. AGE: Years	Months	Days	If less than one day
55	6	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Balto. Transit Co.

FATHER
12. Name John W. Hahn
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Nace
15. Birthplace Pa.

16 (a) Informant Mrs. Grace E. Hahn
(b) Address 3805 Conduit Ave. 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

JUL 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-1944 7.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23-1944 to 7-26-1944 and that I last saw him alive on 7-26-1944

Immediate cause of death: Peritonitis — Duration
Due to: Perforated urinary bladder
Due to:
Other Conditions: Papilloma of bladder
(Include pregnancy within 3 months of death)
Date of operation 7-24-44
Major findings of operation: Papilloma of bladder
of autopsy: Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanni M. D.
Address St. Jos. Hosp. Date signed 7-26-44

G19328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19328 Registered No. 940

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4846 Pimlico Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4846 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. Padgett.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-0426

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife H. Blanche Padgett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1890

8. AGE: Years 54 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Hughesville, Md.
(Town, county, and state)

10. Usual Occupation Sup't. Maintenance

11. Industry or business Linen Thread Corp.

FATHER
12. Name Joseph H. Padgett
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Lamar
15. Birthplace Md.

16 (a) Informant Mrs. H. Blanche Padgett
(b) Address 4846 Pimlico Rd.

17 (a) Burial (b) Date thereof 7/31/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Old Field's Ch. Cem.
Location Hughesville, Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Balto., Md.

19 (a) 7 1944 (b) Thurlow Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26 1944, at 1:15 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D.
Medical Examiner.
Date signed 7/28/44.

G19329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19329 Registered No.

Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 E. 20th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E. 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. CREAMER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Gebhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1880

8. AGE: Years	Months	Days	If less than one day
63	10	10	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Henry W. Snow

FATHER
12. Name William Creamer
13. Birthplace

MOTHER
14. Maiden Name Ella Jane Riley
15. Birthplace

16 (a) Informant Mrs. Katherine G. Creamer
(b) Address 1008 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed JUL 27 1944 (b) Registrar Thruston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26/ 1944, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12-1944 to 7-26-1944, and that I last saw him alive on 7-25-1944

Immediate cause of death	Duration
Coronary occlusion	Sudden
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Lybert M.D.
Address 802 Harford Rd. Date signed 7-27-44

G19330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G19330

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 Brendan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES William JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Spanish American	none	M	W	Married

6 (b) Name of husband or wife Charlotte M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1883

8. AGE: Years	Months	Days	If less than one day
60	9	16	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Retired Police
11. Industry or business Balto., Md.

FATHER
12. Name Jabey Jones
13. Birthplace Indiana

MOTHER
14. Maiden Name Lucinda Crane
15. Birthplace Indiana

16 (a) Informant Mrs. Charlotte M. Jones
(b) Address 3124 Brendan Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944 at 9.25 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of head.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-26-44 at 8:30 P.M.
(b) Where did injury occur? 3124 Brendan Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Shot himself with a 32 cal. Iver Johnson revolver
23. Signature H. L. Williams M.D. Medical Examiner.
Date signed 7-27-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G19331 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 S. Duncan Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Duncan Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANASTASIA WIECZYNSKI

3 (b) If veteran, name war ——— | 3 (c) Social Security Account No. ———

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/78

8. AGE: Years 66 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Adalbert Blaszkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Mionewska
15. Birthplace Poland

16 (a) Informant Mrs. Mary Majerowicz
(b) Address 407 S. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Ave

19 (a) [illegible] 1944 (Date received by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 8:37 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to July 25 1944 and that I last saw h[illegible] alive on July 25 44

Immediate cause of death HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE — Duration 4/4/44

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Wrenga

Address 209 S. Chester St Date signed 7/22/44 M. D.

G19332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 E. FEDERAL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 E. FEDERAL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MUELLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 216-09-8008

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARY E. MUELLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 6 1875

8. AGE: Years 69 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation WATCHMAN

11. Industry or business

FATHER
12. Name GEORGE MUELLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name BARBARA UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MARY E. MUELLER (WIFE)
(b) Address 2510 E. FEDERAL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 29/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler INC.
403 S. WOLFE ST.

JUL 27 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JULY 26 1944, at 4/45M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 194 to July 26 19 44 and that I last saw h[illegible] alive on July 24 19 44

Immediate cause of death: Coronary Thrombosis — Duration: 7 hrs.
Due to:
Due to:
Other Conditions: Decompensating cardio-renal vascular — 1 yr
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David Schneider M. D.
Address 1101 N. Milton Ave Date signed 7-27-44

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19333

BALTIMORE CITY HEALTH DEPARTMENT

TN. 87917 CERTIFICATE OF DEATH 136

G19333
Registered No.

FILE WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months & 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 3718 Foster Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Sappington

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215 03 4386

4. Sex: Male

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1890

8. AGE: Years 53 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation BAGGER AT LAUNDRY

11. Industry or business

FATHER
12. Name Lott Sappington (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Katie Brown (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 29/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler Inc.
(b) Address 403 S. WOLFE ST.

7 1944 Date rec'd by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-44 at 4.00 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1944 to 7-26 1944 and that I last saw him alive on 7-26 1944

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. O'Leary M. D.
Address City Hosp. Date signed 7-26

WILES

G19334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19334 Registered No.

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Erasures or corrections are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5611 Wimmer Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Wimmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Anna R. Wiles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	Widow

6 (b) Name of husband or wife Levi L. Wiles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1855

8. AGE: Years	Months	Days	If less than one day
88	10	7	hr. min.

9. Birthplace Lewistown, Frederick Co. Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Frederick King
13. Birthplace Lewistown, Frederick Co. Md

MOTHER
14. Maiden Name Mary Bowers
15. Birthplace Lewistown, Frederick Co. Md

16 (a) Informant Mrs. James Norris
(b) Address 5611 Wimmer Ave.

17 (a) Burial (b) Date thereof 7-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lorin Boyer
(b) Address 5005 Park Heights Ave.

19 (a) (Date received by registrar) (b) Registrar

JUL 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1944, at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to July 24 1944 and that I last saw h-- alive on July 24 1944

Immediate cause of death: Chronic Valvular Heart Disease — Duration 2

Due to Arteriosclerosis & Arterial Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. E. Masters M. D.
Address Randallstown Date signed 7/26/44

G19335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G19335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 128 Burnett Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 Burnett Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Louisa (Louie) E. Bill

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Wm. H. Hill, Sr.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): January 24, 1878

8. AGE: Years 66 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: At home
11. Industry or business: —

MOTHER / FATHER
12. Name: Albert Klein
13. Birthplace: Balto., Md.
14. Maiden Name: Lena (?)
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Evelyn Foster (Daughter)
(b) Address: 128 Burnett Ave, Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 27-1944 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem. Location: Balto., Md.

18 (a) Funeral director: G. Howard Evans
(b) Address: 1400-02 N. Charles St Balto 30, Md.

19 (Date rec'd by registrar) AUG. 27 1944 Huntington Williams, Registrar, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1944 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 19XX, to 7/26, 19XX, and that I last saw her alive on 7/26, 19XX.

Immediate cause of death: Carcinoma of rectum and bowel. — Duration: 2

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

Signature: Harry Deibel M. D.
Address 1226 Hanover St. Date signed 8/27/1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19336 Registered No. 1200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Dooley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Martin

13. Birthplace ?

MOTHER 14. Maiden Name Mary Birkinam

15. Birthplace ?

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1944 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location Baltimore

18 (a) Funeral director Peter Wiedefeld

(b) Address 914 Greenmount Ave

AUG 27 1944 (Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 2.15 p.

20. DATE OF DEATH July 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 27 1944 and that I last saw h alive on 19

Immediate cause of death: General Postmortem

Due to: Cerebral Hemorrhage

Due to: Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: XXX

of autopsy: none

Duration: 6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence XXXX M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXXX While at work? (Specify type of place)
(e) Means of injury

23. Signature Otto Bucky M.D.

Address 958 E. North Ave. M. D. Date signed 7/28/44

G19337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19337 Registered No. 1204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Warring

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife Emma Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William
13. Birthplace W. Va.

MOTHER
14. Maiden Name Maria Elvira
15. Birthplace Va Va.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulcher
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

JUL 27 1944

MEDICAL CERTIFICATION 8.10 p.m.

20. DATE OF DEATH July 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 24 1944 and that I last saw h alive on

Immediate cause of death Bronchopneumonia Hypostatic

Due to Chr Anemia

Due to Chr Enteritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: XXXX

of autopsy: None

Duration 7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence XXXX at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXXX While at work? (Specify type of place)
(e) Means of injury
23. Signature Otto H. Duker M.D.
Address 928 E. North Ave. Signed 7/28/44

G19338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1200a

G19338

Registered No.

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William

13. Birthplace 1

MOTHER 14. Maiden Name Mary Melody

15. Birthplace 2

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 917 Greenmount Ave

19 (a) Filed JUL 27 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 54m

20. DATE OF DEATH July 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 27 1944 and that I last saw h alive on 19

Immediate cause of death: General toxemia — Duration: 6 days

Due to Chr Diarrhea

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: XXXX

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence XXXX at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXXX While at work?
(Specify type of place)
(e) Means of injury None

23. Signature Chas H. Burke M.D.

Address 926 E. North Ave Date signed 7/28/44

G19339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

G19339
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Whitridge
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Whitridge (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattee B. Gallagher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1864

8. AGE: Years 79 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jno Gillespie
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Balto Md

16 (a) Informant Mrs. Holland
(b) Address 312 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 (a) July 27 1944 (Date registered) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 5th A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1942 to July 26 1944 and that I last saw her alive on July 26 1944

Immediate cause of death Chr. Brights - Uraemia
Cardio. Vascular Renal Disease
Duration July 26/44 Aug 1942

Due to Arterio - Sclerosis - Hypertension -

Due to —

Other Conditions Hemiplegia (Left) 2 Aug 1942
Mellitus Diabetes

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Strenuen M. D.
Address 722 N. Kenwood Ave Date signed July 29/44

G19340 (14)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G19340 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 W. West St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora M. Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles E.

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 5 1880

8. AGE: Years 63 | Months 10 | Days 22 (If less than one day hr. min.)

9. Birthplace: Calvert Co., Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

MOTHER / FATHER

12. Name: Joseph Breeden

13. Birthplace: Md

14. Maiden Name: Catherine Groves

15. Birthplace: Md

16 (a) Informant: Charles E. Clark

(b) Address: 14 W. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 29/44 (month) (day) (year)

(c) Cemetery or crematory: Holy Cross

Location: A. A. Co. Md.

18 (a) Funeral director: Flynn & Flannery

(b) Address: 1426 Light St. (c)

19. 7-27-1944 (b) Registrar

Date of this registration

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/44 19 at 1:15 P

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 44 to July 27 19 44 and that I last saw h alive on 19

Immediate cause of death: Central hemorrhage — Duration: 2 wks

Due to: arteriosclerosis — 2 yrs

Due to: Hypertension — 2 yrs

Other Conditions: Blindness — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Isaac Muller M. D.

Address 226 N. Charles St Date signed 7/27/44

M. D. R. 1268-9

G19341

G19341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1310

1. PLACE OF DEATH Home of the Good Shepherd

Registered No.

CITY OF BALTIMORE: (No. 15 S. Mount St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 81 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Elizabeth Martin

(a) Residence: No. 15 S. Mount St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Saml Martin

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Mary H.

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Sisters of the Good Shepherd

(Address) Mount & Arlington Sts.

18. BURIAL, CREMATION, OR REMOVAL

Place St Peters Date 7-28 1944

19. UNDERTAKER J. J. Fahey & Sons

(Address) 1318 Light St.

FILED JUL 27 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 26, 1944

22. I HEREBY CERTIFY, That I attended deceased from Aug 42 to July 25 1944

I last saw her alive on July 25 1944. Death is said to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Oedema	1 day
Other contributory causes of importance:	
Senile Arteriosclerosis	
Mitral Regurgitation	
Chr. Interstitial Nephritis	years

Name of operation — Date of

What test confirmed diagnosis? Usual Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, when?

(Signed) Geo A Braun M. D.

(Address) 1800 N Charles St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G19342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

G19342
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. & John St.
(c) Hospital or institution: Hosp. for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 30 - md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Annapolis Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Ruth Rachel Prince

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Pvt. Charles W. Prince
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) July 24 1903

8. AGE: Years 42 | Months 0 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name John Fredericks
13. Birthplace Md

MOTHER 14. Maiden Name Mamie Carter
15. Birthplace Md

16 (a) Informant Jesse P. Grimm
(b) Address 395 Simmons St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wilson Gaston
Address 1417 W. Saratoga St.

JUL 27 1944

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944 to 7-26 1944 and that I last saw h er alive on 7-26 1944

Immediate cause of death Peritonitis, acute — Duration ?

Due to Perforated gastric ulcer, chronic

Due to ____

Other Conditions Cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation 7-23-44

Major findings of operation: Perforated ulcer, chronic

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature T. E. Randall, Jr. M.D.
M. D.
Address Hosp. for Women of Md. Date signed 7-26-44

G19343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 26

Registered No. G19343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 9 - 26
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Stoneleigh (If outside city or town limits, write RURAL and give town)
(d) Street No. 7107 Wardman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HAINES, WILLIAM AINSWORTH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12 1929

8. AGE: Years	Months	Days	If less than one day
15	4	13	hr. min.

9. Birthplace Chicago Illinois (Town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business

FATHER
12. Name Louis B Haines
13. Birthplace Cuba, N.Y

MOTHER
14. Maiden Name Estrada Bauer
15. Birthplace Arlington Wis

16 (a) Informant hospital records
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-28-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Pelham Gordon
(b) Address 217 E Lexington St

JUL 27 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944, at 7 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1944, to 7-25 1944, and that I last saw h[illegible] alive on 7-25 1944.

Immediate cause of death	Duration
Due to Bulbar poliomyelitis	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret K. D. Smith M. D.
Address Sydenham Hosp. Date signed 7-27-44

G19344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G19344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 Bank St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Glaser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Eastern Shore Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Unemployed

FATHER 12. Name Gleaser
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Marian Waxelerobi
(b) Address Severn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Mellor & Lester
(b) Address 314 St Paul St

19 (a) JUL 27 1944 (Date rec'd by registrar) (b) Huntington Hillcoat M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 12 25 P.M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H L Wallenmeyer M.D. and Medical Examiner.
Date signed 7-26-44

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G19345 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Payson Sts

(c) Hospital or institution: Bon Secours

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2121 W. Baltimore St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Keating

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Timothy D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1886

8. AGE: Years 57 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Maurice Angland

13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Callahan

15. Birthplace Ireland

16 (a) Informant Mr. Timothy Keating

(b) Address 2121 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director Harry H. Weitzel

(b) Address 1101 Edmondson Ave

19 (a) JUL 27 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25 1944 at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1944 to 7/25 1944 and that I last saw her alive on 7/25 1944

Immediate cause of death Pleural Effusion — Duration 3 wks

Due to Pulmonary tuberculosis 20 yrs

Due to

Other Conditions Hypertension Cardio-vascular disease 3

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Raymond Long M. D.

Address 1 W. Lexington St Signed 7/26/44

G19346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G19346 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette + Payson St

(c) Hospital or institution: Bon Secours. No

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2687 St. Benedict St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (KATHRYN) Catherine Schumann.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ernst K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7 1867

8. AGE: Years 56 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name — Schweininger

13. Birthplace Germany

MOTHER 14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Mrs. Ernst K. Schumann

(b) Address 2687 St. Benedict St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-44 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Dorsey Md

18 (a) Funeral director Harry A. W. Fike

(b) Address 4101 Edmondson Ave.

19 (a) (Date received by registrar) (b) Registrar

JUL 27 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1944 at 2 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1944 to 7/27 1944 and that I last saw h[illegible] alive on 7/27 1944.

Immediate cause of death Peripheral Circulatory failure — Duration 6 hrs.

Due to Intestinal Obstruction — 6 days

Due to Generalized Carcinomatosis — 7

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 7/25

Major findings of operation: Carcinomatosis abdominal viscera

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Raymond Long M. D.

Address [illegible] Date signed 7/27/44

T.B.P.--89186

G19347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G19347

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Elicott Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Rippy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1905

8. AGE: Years 38 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Electrical

11. Industry or business Maryland Dry Docks

FATHER
12. Name George Rippy
13. Birthplace North Carolina

MOTHER
14. Maiden Name Florence McIntire
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)
(c) Cemetery or crematory Gastonia N. Carolina
Location North Carolina

18 (a) Funeral director Mount Brock & Son
(b) Address 900 N. Chester St

19 (a) JUL 28 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24/44 19..., to 7/26/44 19..., and that I last saw h[illegible] alive on 7/26/44 19...

Immediate cause of death: Pleural effusion / Empyema — Duration ?

Due to: Pneumococcus (?)

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Empyema pleural effusion

of autopsy: Febrile pneumococcal pleurisy R.L. R.U.L.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Pheiffer M. D.
Address B C H. Date signed 7-27-44

G19348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G19348 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 00z
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 W. West St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME WILLIAM J WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 267-16-6558

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Wellette

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 11/16/1903

8. AGE: Years	Months	Days	If less than one day
40 41	8	7	.....hr. .....min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name James Wilson
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace N.C

16 (a) Informant Wellette Wilson
(b) Address 518 W West Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28, 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L Brownston
(b) Address 1080 W Montgomery Street

19 (a) July 28 1944 (Date received by registrar) (b) Huntington Holmes, MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1944 at 7 40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-22-44 at ..... M.
(b) Where did injury occur? 601 W Conway St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Revolver - alleged

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 7-23-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G19349

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 N Fremont
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N Fremont (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1886

8. AGE: Years 58 | Months | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjaman Taylor
13. Birthplace Md

MOTHER 14. Maiden Name Louin ?
15. Birthplace Md

16 (a) Informant Pearl Brown (N)
(b) Address 310 N Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director David L Brown rl
(b) Address 10 W Montgomery St

19 (a) [illegible] Washington Williams Mfr

JUL 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1944 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1944 to July 25 1944 and that I last saw her alive on July 24 1944

Immediate cause of death Carcinoma Oesophagus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Scarlett M. D.

Address 1011 W Lee Date signed 7/27/44

G19350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

G19350
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. High St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Randall Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race B
6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ? 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace — ? (Town, county, and state)

10. Usual Occupation Am. Agric. Chem. Co.
11. Industry or business — Laborer

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Howard Harrington
(b) Address — 123 N. High St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 27 1944
Commissioner of Health

18 (a) Funeral director
(b) Address
(Date received by registrar) Huntington Williams, M.D. Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH — July 15 1944, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to July 15 1944, and that I last saw him alive on July 15 1944.

Immediate cause of death Respiratory Failure — Duration —

Due to Meningo-encephalitis. Type 12 pneumococcus. — ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Cook M.D.
Address Mercy Hospital Date signed July 15 1944

for P. C. J. Jablonski by 32030 Howard T. Madden, M.D.

G19351 19351 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G19351 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Payson St. 23 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-22-44

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert
13. Birthplace Md

MOTHER
14. Maiden Name Sturm
15. Birthplace Md

16 (a) Informant T. Dolan
(b) Address St. Agnes Hospital

17 (a) Burial (b) Date thereof 7-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director H. H. Wilson
(b) Address 4101 Edmondson Ave

19 (Date rec'd by registrar) JUL 28 1944 Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24/1944 at 1:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944 to 7-24 1944, and that I last saw h.22 alive on 7/24 1944

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Kaffuce M.D.

Address St. Agnes Hosp. Date signed 7/28/44

G19352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 130

G19352

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 732 Ajax Alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 Ajax Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 27 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1944, at 9:15 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed July 9 1944

F 2032

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19353

BALTIMORE CITY HEALTH DEPARTMENT

TH. 15586 CERTIFICATE OF DEATH 13B

Registered No. G19353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 yrs & 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (Balto. City Hosp.)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1862

8. AGE: Years 81 | Months 8 7 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary McGraw
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th 1944 at 12.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 19 4 to 7/24 19 4, and that I last saw h. alive on 7/24 19 4.

Immediate cause of death (a) Pulmonary Tuberculosis — Duration

Due to Tuberculous Bacilli

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address BCH Date signed 7/26/44

2033

G19354 Surgery D&C

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

G19354 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp - 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto # 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Barrya Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Baby Boy Sachs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S -
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 26, 1944
8. AGE: Years | Months | Days | If less than one day: 2 hr. min.
9. Birthplace Balto. Md - (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name NATE SACHS
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Edith Abramowitz
15. Birthplace Balto. Md.

16 (a) Informant Edith Sachs
(b) Address 3901 Barrya Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 1 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death — Duration

Prematurity (5 mos. pregnancy)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacobs Stuck M. D.
Address Franklin Square Hos. Date signed 7/27/44

VS 3

2034

G19355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G19355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South East. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N Belmont Ave. (Or location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert Lee Herbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1944.

8. AGE: Years 0 Months 0 Days 0 If less than one day 22 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjamin
13. Birthplace St. Mary's Md.

MOTHER 14. Maiden Name Konopik
15. Birthplace Balto. Md.

16 (a) Informant father
(b) Address 535 N. Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Charles E. Schimunek
(b) Address 1601 E. Madison Street

19 JUL 28 1944 (b) Registered by Registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1944 7:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1944 to 7-27 1944 and that I last saw him alive on 7-27 1944.

Immediate cause of death Prematurity.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Beck Jr. M.D. M. D.
Address South East. Gen. Date signed 7-27-44

G19356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G19356 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run
(c) Hospital or institution: Sydenham Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Postman
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin Lebow

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: Child

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 11 1929

8. AGE: Years 14 yrs Months 8 mos Days 16 If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Child - school

11. Industry or business

FATHER
12. Name Solomon Lebow
13. Birthplace Russia

MOTHER
14. Maiden Name Sophie Idenberg
15. Birthplace Russia

16 (a) Informant Sophie Lebow.
(b) Address 2900 Postman

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 7-28-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Park Rd + Bowley Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) [illegible] Registrar

JUL 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1944, to 7-27 1944, and that I last saw him alive on 7-27 1944

Immediate cause of death: Respiratory failure — Duration: ____

Due to: Bulbar poliomyelitis — Duration: 6 days

Due to: ____

Other Conditions: ____

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury

23. Signature Margaret K. D. Smith M. D.

Address Sydenham Hosp. Date signed 7-27

G19357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30 D

Registered No. G19357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Werblem

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Frank Levenson
(b) Address 3820 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jos. Levine & Bro
(b) Address 1439 E. Balto. St

JUL 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944, to July 26 1944, and that I last saw Deceased alive on July 25 1944

Immediate cause of death	Duration
? Rupture of abdominal aortic aneurysm	
Due to	
Due to	
Other Conditions Cystitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Killon M.D.
Address Sinai Hosp. Date signed 7-26-44

G19358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G19358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Patterson Park & Eastern Ave.
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Ramsay St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME GEORGE M. ALLEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Blanche Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 - 1867

8. AGE: Years	Months	Days	If less than one day
77	6	6	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Orlando Allen
13. Birthplace N. Y.

MOTHER
14. Maiden Name Sophronia Allen
15. Birthplace N. Y.

16 (a) Informant Mrs Grace A Allen
(b) Address 1706 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto. Md.

18 (a) Funeral director Geo. L. Bayer Jr
(b) Address 1512 Hollins St

JUL 28 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944, at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1944 to July 27 1944 and that I last saw h.r alive on July 25 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to	
Due to	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Kardash M. D.
Address Univ. Hosp Date signed 7-27-44

G19359
JL - 86277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G19359
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:-
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Beale Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Edwards

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Daisy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day. yr.) Jan. 10, 1888

8. AGE: Years	Months	Days	If less than one day
56	6	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Frances Edwards
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof July 30 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. G. County Md.

18 (a) Funeral director Mrs. Lytle A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) JUL 28 1944 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-44 19 , at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1944 to 7-26 1944, and that I last saw him alive on 7-25 1944

Immediate cause of death: Hypostatic Pneumonia — Duration
Due to Generalized Arteriosclerosis & Arteriosclerosis
Due to Gangrene of Extremities
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6-15-44 ; 7-5-44
Major findings of operations: Arteria Sclerotic Gangrene
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. Moulton M.D.
M. D.
Address Bel Air City Hosp Date signed 7-26-44

G19360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 CLEVELAND ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 42
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 CLEVELAND ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA E LLOYD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CLARENCE J. LLOYD

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) APRIL 20-1895

8. AGE: Years 49 | Months 3 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name MICHAEL GEARY.
13. Birthplace IRELAND

MOTHER
14. Maiden Name SARAH Mc CAUGH
15. Birthplace IRELAND

16 (a) Informant CLARENCE J. LLOYD
(b) Address 1215 CLEVELAND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-30-44 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location BALTO MD

18 (a) Funeral director Bernard C Harker
(b) Address 121 E West St

19 (a) JUL 28 1944 (Date of certificate) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944, to July 26 1944, and that I last saw her alive on July 26 1944

	Duration
Immediate cause of death Myocardial insufficiency	1 day
Due to Chronic Myocarditis	1 yr.
Due to	
Other Conditions Acute Cholecystitis (Include pregnancy within 3 months of death)	1 wk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Shufelbarger M. D.
Address 1802 Eutaw Pl Date signed 7-27-44

G19361

G19361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 N Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside limits, write RURAL and give name of township)
Street No. 827 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gilbert Earl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/2/41

8. AGE: Years 3 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Balto City (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Warren Walton
13. Birthplace Ga.

MOTHER 14. Maiden Name Cleo Earl
15. Birthplace Balto Md

16 (a) Informant Cleo Earl
(b) Address 827 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co Md

18 (a) Funeral director Robt L Williams
(b) Address 1515 McElderry

JUL 28 1944 (Date rec'd by registrar) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1944 to July 26 1944 and that I last saw him alive on July 26 1944

Immediate cause of death	Duration
Pulmonary Embolism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature B. D. Halter M.D.

Address 1 W 25 Pl Date signed July 27 1944

D 19362.

BALTIMORE CITY HEALTH DEPARTMENT ✓ D 19362
Registered No.

CERTIFICATE OF DEATH 126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3808 Granada Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Effie D. Eader

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Columbus Eader
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6/876

8. AGE: Years	Months	Days	If less than one day
67	10	22	hr. min.

9. Birthplace Haynesville, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business --

FATHER
12. Name Dandridge Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Elvira Clark
15. Birthplace Va.

16 (a) Informant Mrs. Florence Stidman
(b) Address 3808 Granada Ave. 7

17 (a) Burial (b) Date thereof 7/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by local registrar) (Signature of local registrar)

VS Mo JUL 29 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28/44 19 at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18/44 19 to 7/28/44 19
and that I last saw h alive on 7/18/44 19

Immediate cause of death Vascular collapse and post-operative shock. — Duration

Due to Operation (cholecystectomy)

Due to Cholecystitis (chronic) Cholelithiasis

Other Conditions Essential hypertension
(Include pregnancy within 3 months of death)

Date of operation 7/27/44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Traynor M. D.
Address Mt. Vernon Hosp. Date signed 7/28/44

G19363

T.C.P. 89063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D G19363 No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Windsor Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Earnest Grauel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jeanette (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1871

8. AGE: Years 72 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER
12. Name Fred Grauel (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Denhardt (d)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (b) Date thereof July 29, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Thos. & Wm. John H. Teufel & Son
(b) Address 894 W. Fayette St. Huntington Williams, M.D.

JUL 28 1944
(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1944 19 , at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19- 1944, to 7-26 1944, and that I last saw h[illegible] alive on 7-26- 1944.

Immediate cause of death	Duration
Cardio decompensation	
Due to Hypertensive cardio vascular Disease	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Phaneuf M. D.
Address BCH. Date signed 7-27-44

T.G.P.-60098

19364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G19364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 North Kenwood Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Stayler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Stayler (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1870 ?

8. AGE: Years	Months	Days	If less than one day
74	8	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Baier (D)
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Mink (D)
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (b) Date thereof July 28 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wilhelm Bros. & Co. Inc
(b) Address 1217 St Paul St

19 (a) JUL 28 1944 Registrar
(rec'd by Registrar)
Huntington Wilhelm, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1944, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1944 to 7/25 1944 and that I last saw h[illegible] alive on 7/25 1944

Immediate cause of death: Bronchopneumonia — Duration 4 days

Due to: Arteriosclerosis

Due to:

Other Conditions: Arteriosclerosis Malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of Rectum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address BCH Date signed 7/26/44

G19365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19365 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 Hayward Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Hayward Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olon G. Roys

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-6776

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ or wife Annie Roys
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11th 1875

8. AGE: Years	Months	Days	If less than one day
69	1	16	hr. min.

9. Birthplace Warren - Vermont (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business At Large

FATHER
12. Name Chauncey Roys
13. Birthplace Vermont

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Annie Roys
(b) Address 4114 Hayward Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) JUL 28 1944 (Date rec'd by Registrar) Huntington Pittsville, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1944 at 8 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to July 26 1944, and that I last saw h~~im~~er alive on July 26 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	9 hrs.
Due to Arteriosclerotic Cerebral Vascular Disease	9 mos. (?)
Due to Generalized Arteriosclerosis Chronic Nephritis	? ?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 N. Howard Ave Date signed 7/29/44

G19366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G19366 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Queen Anne
(a) State Md (b) County Kent
(c) City or town Queenstown (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #2, Box 111 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Washington
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 19, 1891

8. AGE: Years 53 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace (Town, County, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name James Washington
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Claton
15. Birthplace Md.

16 (a) Informant Claton Washington
(b) Address Queenstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30-44 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Grasonville Md

18 (a) Funeral director Lewis A. Heinz
(b) Address Cambridge Md

19 (a) JUL 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27- 1944, at 2 35 P.M.

21. I certify that I took charge of the remains described above, held an Inquest & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock, traumatic

Due to

Other Conditions Fractures, spinous process 7th cervical vertebra + compression 7 x 5th disc
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 67-00
(a) Date of injury 7-25- at ? M.
(b) Where did injury occur? Centreville Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in automobile

23. Signature Howard J. Mussetter M.D. Medical Examiner.
Date signed 7-28-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G19367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 6 mos. 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Sharp Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 - 1889

8. AGE: Years 54 | Months 6 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Engineer & Maintenance man
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hunter
15. Birthplace Ireland

16 (a) Informant Records - City Hospitals
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 28 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Fermanthill Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 131 E Light St

19 7 28 1944 (Date received by local registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 - 19 44, at 1:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia

Due to

Other Conditions Compound Fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-27-44 at 26/E Eutaw St to W. 11 Eaton Corp Summary of Hosp. Record.
(b) Where did injury occur? Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Auto.

23. Signature Howard J. Sessler M.D. Medical Examiner.
Date signed 7-28-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19368 T.B.--84227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 12B

G19368 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs-3 mo.-27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. Rittenhouse & Hall Aves. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Linthicum (Oliver Reck Linthicum)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary C. P.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1867

8. AGE: Years 76 | Months 7 | Days 3 | If less than one day: hr. ____ min. ____

9. Birthplace: Maryland (Baltimore) (Town, county, and state)

10. Usual Occupation: Retired Machinist

11. Industry or business

FATHER
12. Name: John Linthicum
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Martins ?
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1944 19 ____, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1940 to 7/26 1944 and that I last saw him alive on 7/26 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: Last Few Days

Due to: ____

Due to: ____

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: ____

of autopsy: an atom

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury: ____

23. Signature: H. M. Phillips M. D.
Address B C H. Date signed 7-27-44

G19369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57D

G19369 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Harford Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Blaine Mays

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1880

8. AGE: Years	Months	Days	If less than one day
about 63	9	16	hr. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)
10. Usual Occupation Minister (Nazarene)
11. Industry or business

FATHER
12. Name Benjamin Howard Mays
13. Birthplace Maryland

MOTHER
14. Maiden Name Sally Wheeler
15. Birthplace Maryland

16 (a) Informant Harold Sewell
(b) Address 4506 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Glen Coe Cem.
Location Baltimore, County, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 JUL 28 1944 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944, at 8:5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944, to July 27 1944, and that I last saw him alive on July 26 1944.

Immediate cause of death Increased intra-cranial pressure
Due to Brain tumor
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation July 24, 1944
Major findings of operation: Increased intracranial pressure
of autopsy:

Duration: 6 days; 2 mos.; over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Brose
Address Union Memorial Hosp. Date signed 7/29/44

G19370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G19370 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AUGUSTA TESCHNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Oscar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1858

8. AGE: Years	Months	Days	If less than one day
85	11	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jost von Tschudy
13. Birthplace Switzerland

MOTHER
14. Maiden Name Theresa Wagner
15. Birthplace Alsace Lorraine

16 (a) Informant Miss Felice Teschner
(b) Address 3107 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JUL 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 26, 1944, at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944, to July 26 1944, and that I last saw h[illegible] alive on July 26 1944.

Immediate cause of death: Uremia

Due to Chronic nephritis

Due to Cardiac failure

Due to Pyocanitis

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Needle M. D.
Address 2314 - W. North Ave. Date signed 7/29/44

G19371

BALTIMORE CITY HEALTH DEPARTMENT

T.G.P.-88969

CERTIFICATE OF DEATH

30E

G19371

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Exter Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Benton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy Benton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1891

8. AGE: Years 53 | Months 52 | Days 4 | If less than one day hr. min. 7

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name West Benton
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lonnie ?
15. Birthplace South Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph D. Locke, Jr.
(b) Address 1304 N. Central Ave.

19 (a) Date received by registrar JUL 28 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1944 19 , at 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944, to 7/25 1944, and that I last saw h-- alive on 7/25 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 7

Due to: Luetic Heart Disease with aortic insufficiency — Duration: 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address BCH Date signed 7/26/44

Kohlhepp

G19372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

Registered No. G19372

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 N. CAROLINE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. CAROLINE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE LORETTA KOHLHEPP

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: HARRY S. KOHLHEPP

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) NOV. 18-1885

8. AGE: Years 58 | Months 8 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name JAMES H. DUNN
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name CATHERINE L. HORGAN
15. Birthplace BALTIMORE MD

16 (a) Informant HARRY S. KOHLHEPP
(b) Address 1631 N. CAROLINE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) (b) Huntingdon Williamsport, Md.

JUL 28 1944
VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from December, 1943, to July 26 1944, and that I last saw her alive on July 26 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature R. R. Cannon M.D.
M. D.
Address 1701 N. Caroline Date signed July 29/44

G19373 BALTIMORE CITY HEALTH DEPARTMENT G19373

CERTIFICATE OF DEATH

939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1844 W. North ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write R.F.D. and give town)
(d) Street No. 1844 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Lavy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chaim
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Dr Louis Lavy
(b) Address 1844 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-44 (mo.) (day) (yr.)
(c) Cemetery or crematory North Point Rd
Location North Point Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1464 E. Balto St

JUL 28 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to July 27 1944 and that I last saw h. alive on July 27 1944

Immediate cause of death: Chronic Interstitial Nephritis and Acute Congestive Heart Failure — Duration: unknown 1 day

Due to: Chronic Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Ackerman M.D.

Address 1911 W North Ave Date signed 7/28/44

G19374 ✓ G19374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful[ly] correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 E Cross St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edna Boblitz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	

6 (b) Name of husband or wife Chas. F.
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb 4 1899

8. AGE: Years	Months	Days	If less than one day
45	5	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Edward Knight
13. Birthplace Md

MOTHER
14. Maiden Name Ella Anthony
15. Birthplace Md

16 (a) Informant Chas F Boblitz
(b) Address 234 E Cross St

17 (a) Cremation (b) Date thereof 7 29 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dunbar
Location Dunbar Md

18 (a) Funeral director Wilbur Hoffman Inc
(b) Address 1217 E Cold St

19 (a) JUL 28 1944 Thurlington Williams
(Date received by Registrar) (Signature of Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1944, at 9 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1944, to 7-28 1944, and that I last saw her alive on 7-28 19 4.

Immediate cause of death Peritonitis — Duration

Due to appendicitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations gangrenous appendix
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G Slade

Address Franklin Square Hosp Date signed 7/28/44 M. D.

G19375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Guilford Apartments (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Haskins Thomas

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1869

8. AGE: Years 75 | Months 74 | Days 4 | 13 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles Wesley Thomas
13. Birthplace Virginia

MOTHER
14. Maiden Name Mattie Haskins
15. Birthplace Virginia

16 (a) Informant Sister, Mrs Fannie Meade
(b) Address 4909 Roland Ave, Baltimore

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Tilhom & Foe
(b) Address 1219 E Fort Ave

19 (a) Filed JUL 28 1944 (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 4 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944 to July 28 1944, and that I last saw h in alive on July 28 1944

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Waughtrope Jr. M. D.
Address 33 E. University Pkwy Date signed 7/28/44

G19376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19376
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 E. 21th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Edgewood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs.) Minnie A Yearrady

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1894

8. AGE: Years	Months	Days	If less than one day
50	7	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Lieber Bakery

FATHER
12. Name Robert Fahlbusch
13. Birthplace Germany

MOTHER
14. Maiden Name Emily Kralert
15. Birthplace Germany

16 (a) Informant Mrs John Crum
(b) Address 1324 S Ellwood Ave

17 (a) Burial (b) Date thereof 7/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loh Lown
Location Baltimore Md

18 (a) Funeral director Philbrun Corp
(b) Address 1710 Eutaw Pl

19 (a) JUL 28 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1944 at 4:20 M

21. I certify that I took charge of the remains described above, held an Inspection - Examination from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Chester F. Sulbrandt M.D.
Medical Examiner.
Date signed 7/27/44

G19377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G19377

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 S. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-44

8. AGE: Years	Months	Days	If less than one day
		1	24 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Mattis

15. Birthplace

16 (a) Informant Rec'nda.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL JUL 28 1944

18 (a) Funeral director Commissioner of Health -

(b) Address

19 JUL 28 1944 (Date filed by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1944, at 4 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944, to July 21 1944, and that I last saw h[illegible] alive on July 21 1944.

Immediate cause of death: prematurity — Duration 24 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard J. Kerpan M. D.

Address Johns Hopkins Hosp Date signed 7-22

2031

G19378

443570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G19378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2235 Prentiss Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Barron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-23-43

8. AGE: Years	Months	Days	If less than one day
1	2	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emmett Barron
13. Birthplace Md.

MOTHER
14. Maiden Name Julia
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 28 1944

18 (a) Funeral director Commissioner of Health.
(b) Address

JUL 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July-25 1944 at 9.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-26 1943 to July 25 1944 and that I last saw h.e alive on July 25 1944.

Immediate cause of death: Respiratory failure — Duration

Due to: hydrocephalus — 11 months

Due to: Streptococcal meningitis — 4 weeks

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Joel Haney M. D.
Address Johns Hopkins Hosp. Date signed 7-26-44

F 2037

G19379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$2

Registered No. G19379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. Frazier

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 215-01-5754

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1908

8. AGE: Years	Months	Days	If less than one day
36	5	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Shell Oil Co.

FATHER — 12. Name Wm. A. Frazier

FATHER — 13. Birthplace Calvert Co. Md.

MOTHER — 14. Maiden Name Clementine Funeschi

MOTHER — 15. Birthplace Balto. Md.

16 (a) Informant Mrs. Clementine Frazier

(b) Address 1433 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk. Cem.

Location Frederick Rd.

18 (a) Funeral director Fred'k. Krause & Son

(b) Address 1216 N. Charles St.

(c) (By whom certified) (b) Huntington Williams, M.D.

JUL 28 1944

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 19 44, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 19 44 to July 26, 19 44, and that I last saw h[illegible] alive on July 26, 19 44

Immediate cause of death Traumatic Myelitis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Friedman, M.D.

Address 1319 Light St. Date signed July 28, 1944

Dr. Theo. Morrison 11 E. Chase St VE 0044 ✓ G19380

G19380 — CAREW — BALTIMORE CITY HEALTH DEPARTMENT — Registered No.

CERTIFICATE OF DEATH 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3200 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Carew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Catherine Carew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 31st 1870

8. AGE: Years 74 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: —

MOTHER / FATHER

12. Name: Jeremiah Carew

13. Birthplace: Ireland

14. Maiden Name: Bridget Ryan

15. Birthplace: Ireland

16 (a) Informant: William R. Craig

(b) Address: 912 Woodington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)

(c) Cemetery or crematory: Cathedral

Location: Balto Md

18 (a) Funeral director: William Cook Jr

(b) Address: 1217 St Paul Baltimore, Md

19 (a) 7/31/44 (Date received by Registrar) Huntington Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 1944, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/1943 to 7/29/1944, and that I last saw h~~is~~ alive on 7/18/1944.

Immediate cause of death: Carcinoma of Stomach — Duration: Abt 1 yr

Due to: —

Due to:

Other Conditions: Metastases to Liver, Hypertension — Duration: 6 mo.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Theodore H. Morrison M. D.

Address 7128 11E Chase St Date signed 7/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 97

G19381
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 N Wheeler Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Spinnato

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age 9/7/1869

7. Birth date of deceased (mo., day, yr.) 3-20-1860

8. AGE: Years	Months	Days	If less than one day
74	10	24	hr. min.

9. Birthplace Unemployed
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Nicola Spinnato
13. Birthplace Italy

MOTHER
14. Maiden Name Rose
15. Birthplace Italy

16 (a) Informant Mrs Amelia Ashley
(b) Address 1915 Wheeler Ave

17 (a) Burial (b) Date thereof 7-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J Ruck
(b) Address 3305 Harford Rd

19 (a) JUL 28 1944 (b) Hunting for Williamsport
(Date received by Registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 44, to July 26 1944, and that I last saw h alive on July 26 1944

Immediate cause of death Cardiac failure
Due to Arteriosclerosis
Due to Chronic nephritis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N Needle M. D.
Address 2316 N Monroe St Date signed 7/27/44

(over)

G1938 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ G1938 ✓

CERTIFICATE OF DEATH

Registered No. 12182 1938 ✓

PLEASE WRITE PLAINLY—WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 E Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 E Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William R. Coffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26 1871

8. AGE: Years	Months	Days	If less than one day
52	8	-	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Bethlehem Steel Co.
11. Industry or business

FATHER
12. Name James M. Coffman
13. Birthplace W. Va.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Frances Coffman
(b) Address 117 E Cross St

17 (a) Burial Lot 101 (Burial, cremation, or removal) (b) Date thereof 7-29-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Leonard J Ruck
(b) Address 536 Hanover Rd

19 (a) JUL 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26, 1944, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1942 to 7-26, 1944, and that I last saw him alive on 7-25 1944.

Immediate cause of death	Duration
Chronic Hypertrophic Degenerative	2 yr.
Due to Chronic Nephritis	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Ballard M. D.
Address 707 E. Fort Ave. Date signed 7-27-44

G19383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3132 Elliott Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 Elliott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Marchlek

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 19, 1870

8. AGE: Years 74 | Months 12 | Days 67 | If less than one day hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: not known
13. Birthplace: Poland

MOTHER
14. Maiden Name: not known
15. Birthplace: Poland

16 (a) Informant: Mrs. Catherine Stockman
(b) Address: 1203 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.

18 (a) Funeral director: Clarence F. Hoffmann
(b) Address: 1639 N. Broadway

19 (a) (Date rec'd by registrar) JUL 28 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-1944, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weddell M.D.
Medical Examiner.
Date signed 7-26-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19384

BALTIMORE CITY HEALTH DEPARTMENT 46B

CERTIFICATE OF DEATH G19384

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 O'Donnell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Curtis B. Waters

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1887

8. AGE: Years	Months	Days	If less than one day
57	0	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation machinist
11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Baltimore

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant William Waters
(b) Address 3421 O'Donnell St.

17 (a) burial (b) Date thereof 7/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Address 8017 Kenwood Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from May 5 1944 to July 2 1944, and that I last saw h alive on July 19

Immediate cause of death	Duration
Acute Cardiac paralysis	7/25/44
Due to Carcinoma of Stomach	4/1/44
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Bauer M.D.
signed 7/27/44

28 1944

G19385

BALTIMORE CITY HEALTH DEPARTMENT ✓ G19385

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 White Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 White Oak Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mary R. Pope

3 (b) If veteran, name war	3 (c) Social Security Account No.
*******	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ********* 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1855

8. AGE: Years	Months	Days	If less than one day
89	3	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Randolph Pope
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Lee
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nellie Pope Caldwell
(b) Address 4404 White Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Keomeyers & Son
(b) Address 805 N. Calvert St.

(a) JUL 28 1944 Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION 10.15

20. DATE OF DEATH July 27/44 19 , at p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944 to 19 , and that I last saw h alive on 19 .

Immediate cause of death General toxemia — Duration

Due to Carcinoma of the left breast + — Duration

Due to metastases — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur W. Kac M. D.
Address 7862 Dolfield Date signed 7-28-44

G19386 | BALTIMORE CITY HEALTH DEPARTMENT | G19386 Registered No.

CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 W. Lanvale St.
(c) Hospital or institution:
Miss Judge's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Do not know (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Fahey

3 (b) If veteran, name war	3 (c) Social Security Account No.
**********	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ********
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
About 80	?	?	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Not obtainable
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Not obtainable
15. Birthplace Not obtainable

16 (a) Informant Mrs. Helen Warwick
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Myers and Son
(b) Address 805 N. Calvert St.

19 (a) Registrar Huntington Williams M.D. (b) Registrar

JUL 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 44, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1942 to July 28 1944, and that I last saw h.. alive on July 26 19 44.

Immediate cause of death Uremia Myocarditis — Duration

Due to

Due to

Other Conditions Arterial sclerosis - Sclerosis. — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J Schaub
Address 701 N. Fremont Ave Date signed 7/29/44

G19387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

G19387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Park Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Ellen E. Tucker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Herbert Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1883

8. AGE: Years	Months	Days	If less than one day
60	11	7	hr. min.

9. Birthplace Towson, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James W. Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emily S. Gibbons
15. Birthplace Baltimore, Md.

16 (a) Informant Herbert Tucker
(b) Address 1627 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)
(c) Cemetery ~~Druidridge~~ Loudon Park
Location 3801 Frederick Ave,

18 (a) Funeral director John A. Mitchell & Sons, Inc.
(b) Address 1908 Eutaw Place

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

JUL 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1944, to July 27 1944, and that I last saw h. alive on July 27 1944

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to Chr. Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur C. Morningstar M. D.
Address 800 E. North Ave. Date signed

G19388
312031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19388
Registered No. 47D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Greenwood (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ann Sloan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-18

8. AGE: Years	Months	Days	If less than one day
26	5	9	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Allen Gresham
13. Birthplace Ga.

MOTHER
14. Maiden Name Annie Marshall
15. Birthplace S.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 7 28 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenwood S.C.
Location

18 (a) Funeral director Philip Hering Sons
(b) Address 2024 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944 at 4 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to July 28 1944 and that I last saw deceased alive on July 28 1944

Immediate cause of death Cerebral hemorrhage — Duration 5 Mins

Due to Metastasis of — Duration 1

Due to Sarcoma of Skull, brain, & lungs — Duration 5 yrs

Other Conditions Granulosa Cell tumor of Ovary left — Duration 10 Mos
(Include pregnancy within 3 months of death)

Date of operation 4-16-29 - Removal sarcoma of Skull. 1-21-44 - Removal of Granulosa Cell tumor, left ovary

Major findings of operation

At autopsy Not performed by family

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Landrum B. Shettles M.D.
Address Johns Hopkins Hospital Date signed 7-28-44

G19389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 166 W. Hoff Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dan allen Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21 1928

8. AGE: Years	Months	Days	If less than one day
15	10	26	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation School boy
11. Industry or business

FATHER
12. Name Dan B Johnson
13. Birthplace N.C.

MOTHER
14. Maiden Name Mrs Fannie L Sutton
15. Birthplace N.C.

16 (a) Informant Lula Spells
(b) Address 1664 West Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 29 44 (month) (day) (year)
(c) Cemetery or crematory
Location Fayetteville N.C

18 (a) Funeral director Sarah J Brown Son
(b) Address 1086 Montgomery Street

19 (a) Date received by registrar JUL 28 1944 (b) Registrar Huntington Hill, M.D.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1944, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH accidental drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/26/44 at 12 17 25/6 P. M.
(b) Where did injury occur? Masonville (Patapsco River)
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury washed out to deep water
23. Signature [illegible] M.D. Medical Examiner.
Date signed 7-26-44

G19390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: D.O.A. Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Exeter St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Anthony Figliseppe

3 (b) If veteran, name war	3 (c) Social Security Account No.
no.	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) P

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Balto City Removal

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lillian McGunagle
(b) Address 626 S. Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July (month) (day) 1944 (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Wendell J. Lippel
(b) Address 312 S. Highland Ave

19 (a) JUL 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25 1944, 11:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Hugh B. McCaleb Medical Examiner.
Date signed 7/26/44.

Physicians: please write the correct age is especially important.

G19391
455673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

G19391
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 302 N. Oldhams Ln
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Adam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-85

8. AGE: Years 59 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Joseph Kramer
13. Birthplace Germany

MOTHER 14. Maiden Name Mary
15. Birthplace France

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loud Heart
Location O'Donnell Sta

18 (a) Funeral director John B. Connelly
(b) Address 46 Eastern Ave.

19 (a) Filed 1944 Registrar Huntington Williams, M.D. Registrar
(b) Recorded by registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1944 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to July 26 1944 and that I last saw him alive on 19

Immediate cause of death: Cerrhosis of liver — Duration

Due to (Laennec's)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Bringhurst M. D.
Address JHH Date signed 7/26

G19392

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 83c

Registered No. G19392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/5/44 12
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/5/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town) 16
(d) Street No. 30 S.a 38th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE EDWARD MARSTERS

3 (b) If veteran, name war: -
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/1874

8. AGE: Years	Months	Days	If less than one day
70	4	14	hr. min.

9. Birthplace ? Novia Scotia (Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Merchant Marine

FATHER
12. Name Dan Marsters
13. Birthplace Novia Scotia

MOTHER
14. Maiden Name Emily ?
15. Birthplace Novia Scotia

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Boland & ave
18 (a) Funeral director A. Lee, Oden
(b) Address 4644 York Rd.
19 (a) Date received by registrar JUL 28 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH July 27, 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5, 1944, to July 27, 1944, and that I last saw him alive on July 27, 1944

Immediate cause of death: Diffused degeneration and necrosis of the brain stem and both cerebellar hemispheres — Duration: Unk.

Due to: Generalised arteriosclerosis — Unk.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. X. Albrecht M. D.
Address Baltimore, Md. Date signed 7/27/44

MS-53980

G19393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 M.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. - 2
(If outside city or town limits, write RURAL and give County)
(d) Street No. 603 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Matukaitus, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1909

8. AGE: Years 34 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Gibbs Packing Co

FATHER
12. Name George Matukaitus
13. Birthplace Lithuania

MOTHER
14. Maiden Name Anna Rooki
15. Birthplace Lithuania

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory
Location Prince - W. Va

18 (a) Funeral director A. J. Seay, Oden
(b) Address 46 E. York St.

19 JUL 28 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1944, at 205 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19 1944 to 7/28 1944, and that I last saw h[illegible] alive on 7/27 1944.

Immediate cause of death: Card. Failure — Duration

Due to Anemia

Due to Chr. Nephritis?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. M. N. Crosby
Address Mercy Hosp. Date signed 7/28

G19394 — Burth 4731 — BALTIMORE CITY HEALTH DEPARTMENT — G19394

CERTIFICATE OF DEATH 161c

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 N. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Lee — Baby Boy Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day ____ hr. ____ min.

9. Birthplace: Balto, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Callie Lee
13. Birthplace: Sumter Co. Ga

MOTHER 14. Maiden Name: Mary Gardner
15. Birthplace: Sumter Co Ga

16 (a) Informant: Birth Cert.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location: UNIVERSITY MEDICAL SCHOOL JUL 21 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) JUL 29 1944 (Date rec'd by registrar) (b) Huntington Hillsmeyer Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1944, at 7 1. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemorrhagic disease of newborn

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. T. Williamson M.D.
Medical Examiner.
Date signed

2038

G19395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1164 C

Registered No. G19395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Pearl Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 53 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 28 1944

18 (a) Funeral director Commissioner of Health

(b) Address

JUL 29 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1944, at 1 50 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of head

Due to Suicide

Other Conditions Mental Dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-1 at M.
(b) Where did injury occur? 102 Pearl Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Revolver

23. Signature H. J. Wollenweber M.D. Medical Examiner.
Date signed July 14, 1944.

2040

G19396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Hospital 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Oldham Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Albert Hundaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 34 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name.....
13. Birthplace

MOTHER 14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 29 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

2039

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1944 at 5 10 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fatty degeneration of liver
Due to Cirrhosis of Chronic Glomerulonephritis

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Per Robert Lee Graham, M.D. M.D.
Medical Examiner.
Date signed 7-28-44

Howard J. Mullen M.D.

Every item of information should be carefully supplied. The physician who certifies to the cause of death should write the causes of death clearly and legibly. Where the exact age is not known, it should be approximated. Please write correct age is especially important. Physicians: please write

G19397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1133a

Registered No. G19397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Park ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Garrett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1887
8. AGE: Years 57 Months Days If less than one day hr. min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John W. Garrett
13. Birthplace md

MOTHER
14. Maiden Name Susan Waters
15. Birthplace md

16 (a) Informant Wilbert Garrett
(b) Address 1105 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Q-A. Co. Md

18 (a) Funeral director James A Hayes
(b) Address 1142 W Fayette St

JUL 29 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27- 1944 at 12:40 AM

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pyelonephritis
Due to
Other Conditions Acute Cystitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-28-44

VS 151

A certified copy or information blank of certificate of death is required before burial or removal. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G19398 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md Gen Hosp
(c) Hospital or institution: Madeira & Linden Ave 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Roundhill Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Kern

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Marie L. Kern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1866

8. AGE: Years 78 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Federal Tin Co.

FATHER
12. Name John —
13. Birthplace Germany

MOTHER
14. Maiden Name Fredrika Wendt
15. Birthplace Germany

16 (a) Informant Mrs. Marie Louise Kern
(b) Address 1636 Roundhill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 29 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1944, at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1944, to 7-27 1944, and that I last saw h[illegible] alive on 7-27 1944

Immediate cause of death	Duration
Carcinoma	
Due to Carcinoma of the Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo B. Gallagher M. D.
Address Maryland Gen Hosp Date signed 7/27/44

Leo B. Gallagher

G19399

G19399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3907 Foster Avenue

(c) Hospital or institution:

2-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3907 Foster Ave (If rural give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3 (a) **FULL NAME** MARY MARGARET MOBRAY

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Rudolph

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1886

8. AGE: Years: 57 Months: 9 Days: 17 If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER: 12. Name: John Bollack

13. Birthplace: Baltimore, Md

MOTHER: 14. Maiden Name: Mary Frances Slipper

15. Birthplace: Baltimore, Md

16 (a) Informant: Henry R. Mobray

(b) Address: 3907 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 29-44 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn

Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc

(b) Address: North Ave. & Broadway

19 (a) (b) Registrar

JUL 29 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944, to July 28 1944, and that I last saw h[illegible] alive on July 28 1944

Immediate cause of death: Pulmonary Edema

Due to: Arterio-sclerotic Cardiovascular Disease

Duration: 8 yrs.

Due to: Acute Heart Failure (Surgical)

2 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Lucien E. Little

Address 10 W Madison St. Date signed 7/29/44

G19400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G19400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wildwood & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3051 Fred. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Dunn
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-07-9668

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Amelia B Dunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 9/1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
72	6	19		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Brush Maker
11. Industry or business Wd Fibre Ceo

FATHER 12. Name Bernard Dunn
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Amelia B Dunn
(b) Address 3051 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1/1944 (month, day, year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Harry N. Amacost
(b) Address 4204 Ridgewood Ave

19 (a) JUL 29 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1944, at 4:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1944, to 7-28 1944, and that I last saw h[illegible] alive on 7-28 1944.

Immediate cause of death	Duration
Pulmonary Embol	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. R. Raffucci M.D.
Address Stayner Date signed 7/28/44

G19401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G19401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 W. Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leaonia Skinner McConnell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Edward McConnell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1921

8. AGE: Years	Months	Days	If less than one day
23	4		hr. min.

9. Birthplace N. C.
(Town, county and state)
10. Usual Occupation Hsf.
11. Industry or business

FATHER
12. Name Louis Nixon
13. Birthplace N. C.

MOTHER
14. Maiden Name Ameta Skinner
15. Birthplace N. C.

16 (a) Informant Mrs. Edwardine McConnell
(b) Address 1012 W. Franklin St.

17 (a) Burial (b) Date thereof July 29, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 JUL 29 1944 Huntington Williams Funeral Dir.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-44 19 at 12.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23-44 to 7-26-44 and that I last saw h[illegible] alive on 7-26-44

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic C. V. Disease	
Due to	
Other Conditions Pregnancy (7 months)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Thomlow Phil M.D.
Address Univ. Hosp. Date signed 7-27-44

VS 150

G19102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. G19102

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 N Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Waugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1943

8. AGE: Years	Months	Days	If less than one day
	10	18	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fulton Waugh
13. Birthplace Glasscock Va

MOTHER
14. Maiden Name Flora Rawlings
15. Birthplace Baltimore, Md

16 (a) Informant Flora Waugh
(b) Address 327 N. Carrollton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 [illegible] 29 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 11:59 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1944, to July 26 1944, and that I last saw h alive on July 26 1944.

Immediate cause of death	Duration
Malnutrition	
Due to	
Due to	
Other Conditions: Secondary Anemia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G J Burgess
Address Provident Hosp Date signed 7/29/44

G19403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G19403 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Butler Sinnott

3 (b) If veteran, name war No | 3 (c) Social Security Account No. 218-05-3173

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1872

8. AGE: Years	Months	Days	If less than one day
71	8	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Doorman
11. Industry or business Mayfair Theater

FATHER
12. Name James Sinnott
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace Ireland

16 (a) Informant Mr. Wm. C. Sinnott
(b) Address 3815 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) JUL 29 1944 (Signature and address)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1944 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1944 to 7-27 1944, and that I last saw h. alive on 7-27 1944.

Immediate cause of death	Duration
Respiration Arrest	
Due to Uremia	
Due to Pyelonephritis Benign Prostatic Hypertrophy	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Rinehart M. D.
Address University Hosp. Date signed 7-28-44

G19404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19404
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3937 Clovehill Rd (=18 City)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Christie Whitney Frazer

3 (b) If veteran, name war: —
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace C. Frazer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/1875

8. AGE: Years	Months	Days	If less than one day
68	8	28	hr. min.

9. Birthplace Lexington, Kentucky
(Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business Johns Hopkins University

FATHER
12. Name Joseph B. Frazer
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary Jane Filson
15. Birthplace Ky.

16 (a) Informant Mrs. Joseph C.W. Frazer
(b) Address 3936 Clovehill Rd. Balto. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JUL 29 1944 (b) Huntington Mattingly M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944 to July 28 1944, and that I last saw him alive on July 27 1944

Immediate cause of death: Cardiac failure — Duration: —
Due to: Coronary thrombosis — Duration: 2 days
Due to: — Duration: —
Other Conditions: — Duration: —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature: Glenn P. Grove
Address Union Memorial Hosp Date signed 7/28/44

G19405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19405 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 S Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Miller Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Bertha Harris
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar - 14 - 1886

8. AGE: Years 58 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Crozette - Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business National Biscuit Co

FATHER
12. Name George Harris
13. Birthplace Crozette Va

MOTHER
14. Maiden Name Judy —
15. Birthplace Crozette Va

16 (a) Informant Bertha Harris
(b) Address 519 S. Sharp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 126 W Montgomery St

19 (a) JUL 29 1944 (Date rec'd by registrar) Hamilton Riddick Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 26 1944, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 2 1944 to July 26 1944 and that I last saw ... alive on July 26 1944

Immediate cause of death Uraemia — Duration

Due to Chronic Nephritis 10 years

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trauner M. D.
Address 1222 W Lee St Date signed 7/26/44

G19406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No. G19406

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Eaton Hall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband/or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11 1912

8. AGE: Years 31 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Williams
13. Birthplace N. C.

MOTHER
14. Maiden Name Mayde Dillard
15. Birthplace Va

16 (a) Informant Delba L'Evine
(b) Address 208 Dalton Street

17 (a) ~~Burial~~ (Burial, cremation, or removal) (b) Date thereof July 29 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B A Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address (0 & 0) Montgomery St

19 (a) JUL 29 1944 (Date rec'd by registrar)

VS 151 For S. A. L. Wollenweber By, Howard L. Calderia M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 44, 19, at 10:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/27/44 at 9A. 25/5 M.
(b) Where did injury occur? Swift & Co Curtis Bay
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury operating a sampling machine when there was a short circuit & he was electrocuted.

23. Signature Henry L. Wollenweber M.D.
Medical Examiner.

Date signed July 27, 1944.

G19407

G19407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5375 Bosworth Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5375 Bosworth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Knell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William T. Knell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11" 1863

8. AGE: Years 80 Months 9 Days 17 If less than one day hr. min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Geo. Wolfe
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Leitz
15. Birthplace Germany

16 (a) Informant Mrs. A. H. Sprecher
(b) Address 5375 Bosworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Co. Md.

18 (a) Funeral director Leslie Lawrence
(b) Address 1715 Hollins Ave

19 (a) JUL 29 1944 (Date rec'd by registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 7:56 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26/44 to 7/28/44 and that I last saw h[illegible] alive on 7/25/44

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Arteriosclerosis — Duration ?

Due to — Duration .

Other Conditions Cardiac Hypertrophy — Duration ?
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. O. Harper
Address 5701 Sargeant Oak Date signed 7/29/44

VS 3

G19408 — BALTIMORE CITY HEALTH DEPARTMENT — G19408

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 69 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Addie Williams
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-16-0810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1920

8. AGE: Years	Months	Days	If less than one day
24	2	13	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation School teacher
11. Industry or business

FATHER
12. Name Charles R. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Houck
15. Birthplace Md.

16 (a) Informant Mary Williams
(b) Address Hampstead, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1/44 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Hampstead Md

18 (a) Funeral director Edw A Tipton
(b) Address Hampstead Md

JUL 29 1944 (a) (b) Huntington Hallowell, Md
(Date received by local registrar) (Signature of local registrar)

VS 180 J1

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1944, at 6 27 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31 1944, to 7-29 1944, and that I last saw her alive on 7-29 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Pernicious endocarditis	
Due to	
Other Conditions Disseminated lupus erythematosus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Lynn M. D.
Address University Hospital Date signed 7-29-44

G19409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G19409 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Smallwood (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME David Blair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. ~~Married~~ Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 6, 1943

8. AGE: Years 1 | Months 3 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Richard J. Blair
13. Birthplace Pa

MOTHER
14. Maiden Name Lillian M. Greene
15. Birthplace Kentucky

16 (a) Informant Richard J. Blair
(b) Address 110 N. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director C. Shemanski & Donovan
(b) Address 2611 Eastern Ave.

19 (a) JUL 29 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1941, at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia Broncho

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Hugh B. Devilbiss, M.D. Medical Examiner.
Date signed 7/28/44

Huntingtown Williams Md

G19410 1902 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19410 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Monument & Rutland
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6210 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Robinson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1876

8. AGE: Years 67 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace: Detroit, Mich. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Isaac Davis
13. Birthplace: Holland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Canada

16 (a) Informant: Mr. Frank Robinson
(b) Address 6210 Pk. Hgts. Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/30/44 (month) (day) (year)
(c) Cemetery or crematory: Temple Beth-El
Location: Detroit, Michigan.

18 (a) Funeral director: Abid Lindheim & Levy
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VR JUL 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1944, at 9:14 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1944, to 7/28 1944, and that I last saw her alive on 7/28 1944.

Immediate cause of death: Respiratory failure — Duration:

Due to: Cerebro vascular accident

Due to: Hypertensive arterio-sclerosis

Other Conditions: Myocardial hyper Diabetes (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Not performed R. dvi.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Leonard Akman, M.D.
Address: Sinai Hosp. Date signed 7/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G19411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 460

G19411 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital 130
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marie Hess

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Louis E. Hess

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1877

8. AGE: Years 66 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name Sody Salabes

13. Birthplace Holland

14. Maiden Name Etta Lenyt

15. Birthplace Balt. Md.

16 (a) Informant Mr. Louis E. Hess
(b) Address Esplanade Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balt. Hebrew
Location Balto. Md.

18 (a) Funeral director Sinai Memorial Home
(b) Address 1902 Eutaw Place

19 (a) (Date received by local registrar) JUL 29 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944, at 10.39 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944, to July 27 1944, and that I last saw her alive on July 27 1944

	Duration
Immediate cause of death: Cardio-respiratory failure	
Due to: Carcinoma of stomach	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation July 20, 1944

Major findings of operation: Anaplastic carcinoma of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Sinai Hospital Date signed 7/27/44

G19412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19412 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Every item of information should be carefully supplied. The use of "unknown" should be avoided. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Aged Home (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sylvan L. Hirshberg (Sylvan L. Hirshberg)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Lewis Hirshberg

13. Birthplace Balto. Md.

14. Maiden Name Rebecca Pollock

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Sadie Rasconer

(b) Address 2301 Carlton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director Harid Sandheim & Son

(b) Address 1902 Eutaw Place

19 (a) JUL 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1944, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1944, to 7/28 1944, and that I last saw him alive on 7/28 1944.

	Duration
Immediate cause of death: Myocardial insufficiency	
Due to: Coronary occlusion	
Due to: Arteriosclerotic heart dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Akman, M.D.

Address Sinai Hosp. Date signed 7/29/44

G19413 DANAHER G19413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 32 S Patonnas St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 32 S Patonnas St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary M. Danaher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joseph J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1880

8. AGE: Years	Months	Days	If less than one day
63	9	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER

12. Name Thomas Flynn

13. Birthplace Ireland

MOTHER

14. Maiden Name Margaret Gibbins

15. Birthplace Ireland

16. (a) Informant Joseph Danaher

(b) Address 32 S Patonnas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem

Location Old Frederick Road

18 (a) Funeral director John E Koran

(b) Address 5600 E Baltimore St

19 (a) [illegible] 29 1944 (Date received by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1944 to July 27 1944 and that I last saw h[illegible] alive on July 25 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 7/27/44

Due to: Hypertension — 1944

Due to: Arteriosclerosis — 1944

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E J Beachman M. D.

Address 950 S Ext Ave Date signed 7/28/44

BLECHMAN

G19414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 E Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Wessly.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sadie Wessly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9-1861

8. AGE: Years 82 | Months 11 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business Asst Street Lighting

FATHER 12. Name Dont Know

13. Birthplace Austria

MOTHER 14. Maiden Name Dont Know

15. Birthplace Austria

16 (a) Informant Miss Katharine Connor

(b) Address 2312 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 44 (month) (day) (year)

(c) Cemetery or crematory Lehnert's Cem Balto Md

Location

18 (a) Funeral director Wilhelm Funeral Home

(b) Address 2004 Orleans St

19 (a) (Date received by local registrar) JUL 29 1944 (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1942 to July 26 1944 and that I last saw him alive on July 26 1944

Immediate cause of death	Duration
(a) Acute Heart Failure	
Due to (b) Chronic Myocarditis	3 yrs
Due to (c) Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Lyons M. D.
Address 876 Wilkens Ave Date signed 7/29/44

G19415

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 74a

G19415
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Colvert St.
(c) Hospital or institution:
Union Memorial Hospital. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. _____ (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3 (a) FULL NAME Mr. Robert Edwin Malone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. R. E. Malone.

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1910.

8. AGE: Years 33 | Months 8 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation U.S. Govt. Guard.

11. Industry or business Ord. Depot, Emmitsburg

FATHER
12. Name Ernest Slemmons Malone
13. Birthplace Maryland.

MOTHER
14. Maiden Name Margaret Farlow
15. Birthplace Maryland.

16 (a) Informant ref.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31, 1944 (month) (day) (year)

(c) Cemetery or crematory Sherwood
Location Cockeysville Md

18 (a) Funeral director London & Burke
(b) Address Sparks, Md

19 (a) _____ (b) _____
Date rec'd by registrar Clayton Williams, M.D. Registrar

JUL 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1944, at 10 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1944, to 7-29 1944, and that I last saw him alive on 7-29 1944.

	Duration
Immediate cause of death: cardio-respiratory failure.	
Due to: acute myeloid leukemia.	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Claffee M. D.
Address Union Memorial Hospital. Date signed 7-29-44

G19416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

G19416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Whitelock St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Goldscheider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/1898

8. AGE: Years	Months	Days	If less than one day
46	4	6	hr. min.

9. Birthplace Connecticut
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Jacob Asch
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Gann
15. Birthplace Russia

16 (a) Informant Henry H. Goldscheider
(b) Address 607 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 JUL 30 1944 Huntington Williams, M.D. Registrar
(Date Rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 2,56

20. DATE OF DEATH July 29, 1944, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1943 to July 28 1944, and that I last saw her alive on July 28 1944.

Immediate cause of death Cerebral carcinomatosis — Duration

Due to Uterine Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. G. Homstein M.D.
Address 733 Anquith St. Date signed 7/31/44

G19417

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G19417

CERTIFICATE OF DEATH 131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and supplied as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Wilson pl.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Deerfield Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1884

8. AGE: Years	Months	Days	If less than one day
60	7	7	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Horseman
11. Industry or business Private Family

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. F. G. Baldwin (employer)
(b) Address Owings Mills, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-44 (month) (day) (year)
(c) Cemetery or crematory St. Thomas'
Location Garrison Forest, Md.

18 (a) Funeral director Lewis M. Dorsey
(b) Address 1 [illegible] Dr. Hilleary, M.D.

JUL 30 1944 (b) [illegible]
(Date dead by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremic nephritis / arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 7-29-44

G19418 BALTIMORE CITY HEALTH DEPARTMENT G19418
CERTIFICATE OF DEATH 95c
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Williamsport (If outside city or town limits write RURAL and give town)
(d) Street No. 483 Hepburn St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN HALPRIN

3 (b). If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Williamsport Pa (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Bora
15. Birthplace Russia

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-44 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Williamsport Pa.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St. Huntington Williams, M.D.

19 (a) JUL 31 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1944, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1944, to 7-28 1944, and that I last saw h~~im~~ alive on 7-28 1944.

	Duration
Immediate cause of death Pulmonary edema, acute	
Due to Or pulmonale	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cor pulmonale, edema, acute

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital Date signed 7-29-44

BALTIMORE CITY HEALTH DEPARTMENT ✓ G19419

G19419 CERTIFICATE OF DEATH 93E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Patchet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widower

6 (b) Name of husband or wife James 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Alfred Jones
13. Birthplace Baltimore

MOTHER 14. Maiden Name Sarah
15. Birthplace Grey

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof July 31 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 250 44

MEDICAL CERTIFICATION 3.4 m.

20. DATE OF DEATH July 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to July 28 1944 and that I last saw h[illegible] alive on July 28 1944

Immediate cause of death Hemorrhage of bowels — Duration 2 days

Due to Hypocondritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: XXXX

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence XXXX at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXXX While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Dietrich Dicke M.D.
Address 928 E. North Ave Date signed 7/29/44 M. D.

319038 G19420

BALTIMORE CITY HEALTH DEPARTMENT ✓ G19420 Registered No.

CERTIFICATE OF DEATH 74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Oppenheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Olga
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 7-8-72

8. AGE: Years	Months	Days	If less than one day
72	-	20	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Ferdinand Oppenheimer
13. Birthplace (Ger)

MOTHER
14. Maiden Name ? Mayer
15. Birthplace (Ger)

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friedale
Location
18 (a) Funeral director Jos Lewis Inc
(b) Address 1439 Balto. St

JUL 30 1944 (b) Registrar
(Date filed by registrar)

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28- 1944 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1944 to 7-28 1944 and that I last saw h[illegible] alive on 7-8- 1944.

Immediate cause of death: Pulmonary embolus — Duration
Due to: Thrombophlebitis
Due to: ~~lat~~ right leg
Other Conditions: Chronic lymphoid leukemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John K. Bermingham M.D.
Address JHH Date signed 7/28/44

G19421 BALTIMORE CITY HEALTH DEPARTMENT G19421
Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Queen Spring Ave.
(c) Hospital or institution: Hebrew Home for Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hebrew Aged Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Ezerstay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sam Ezerstay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Daniel Fried
13. Birthplace: Russia

MOTHER
14. Maiden Name: Leynah-
15. Birthplace: Russia

16 (a) Informant: Abraham Fried
(b) Address: 419 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-30-44 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew Cem.
Location: Wash. Blvd.

18 (a) Funeral director: Jacob Lewis Inc
(b) Address: 1439 E. Baltimore St

19 (a) Huntington Williams M.D.
(Date received by registrar)

30-1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1944, to 7-28 1944, and that I last saw h.. alive on 7-28 1944.

Immediate cause of death: Cerebral Arteriosclerosis | Duration
Hypertension Chr card.
vascular disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H Edmund Levin M.D.
Address: Levindale Date signed: 7/28/44

G19422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19422 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be returned, supplied if unknown. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give road)
(d) Street No. 526 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Catherine Ferretti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Antonio Ferretti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1871

8. AGE: Years	Months	Days	If less than one day
73	5	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas F. Buehler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna E. Schimpf
15. Birthplace Baltimore Md.

16 (a) Informant Antonio Ferretti
(b) Address 526 W Lexington St

17 (a) Burial (b) Date thereof 7-31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Lorman E. Byers
(b) Address 525 Light St. Baltimore Md.

JUL 30 1944

19 (a) (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944 to July 28 1944 and that I last saw her alive on July 27 44

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions Ovarian Tumor

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard St Date signed 7/29/44

G19423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G19423 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Calvert St.
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (if outside city or town limits, write RURAL and give town)
(d) Street No. 114 Ridgewood Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Ridgely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Erwin A. Ridgely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1898

8. AGE: Years 46 Yrs. | Months 7 0 | Days 0 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James L. Sellman.
13. Birthplace Md.

MOTHER
14. Maiden Name Azzie L. Kerger.
15. Birthplace Winchester Va.

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Henry Wyatt Hopkins
(b) Address 9 Richard St. Monument

19 (a) JUL 30 1944 (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1944 at 2 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1944, to 7/28 1944. and that I last saw h alive on 7/28 1944

Immediate cause of death: Respiratory Failure — Duration

Due to Carcinoma of Lung — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Queen M. D.

Address Mercy Hosp. Date signed 7/29/44

G19424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G19424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and answered as fully as possible. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA LAWSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Catonsville Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Lawson
13. Birthplace Catonsville Md

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 31-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Henry W Jenkins
(b) Address Orchard & The Cullod

19 JUL 30 1944 (Date rec'd by registrar) (b)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944 at 1 30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinomatosis of Liver
Anemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. J. Wollenmeber M.D. Medical Examiner.

Date signed 7-26-44

G19425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19425 Registered No. 36

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Middle River
(c) City or town Victory Vila
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Fuselage Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FARABAUGH, Robert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1934

8. AGE: Years	Months	Days	If less than one day
10	2	3	hr. min.

9. Birthplace Spangler PA. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Edwin Farabaugh
13. Birthplace PA.

MOTHER
14. Maiden Name Ann Burke
15. Birthplace PA.

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell Str Rd.

18 (a) Funeral director John B. Connelly
(b) Address 718 Eastern Blvd.

JUL 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944, to 7-28 1944, and that I last saw him alive on July 24 1944.

Immediate cause of death	Duration
Due to bulbar poliomyelitis	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 7-28-44

G19426 ARVel G19426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sand Balto. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3546 Norton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arvel Settle

3 (b) If veteran, name war: N
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Sngle

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28. 1924

8. AGE: Years	Months	Days	If less than one day
19	10	1	hr. min.

9. Birthplace Penn (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Bethlehem Steel Co

FATHER 12. Name Percy Settle
13. Birthplace Penn

MOTHER 14. Maiden Name Eva Hutchinson
15. Birthplace Penn

16 (a) Informant Percy Settle
(b) Address Knoxville Penn

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory Smedley
Location Smedley Penn

18 (a) Funeral director Wilson & Cookson
(b) Address 1217 Pond St

19 (a) JUL 30 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1944, at 1 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/29/44 at 12 A 30 25/5 M.
(b) Where did injury occur? Curtis St. Bridge near Fenmore on Curtis
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury fell out of car when auto struck bridge

23. Signature [illegible] M.D. Medical Examiner.
Date signed 7-29-44

G19427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G19427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma G. Neubaum

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Archie G

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1877

8. AGE: Years 66 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER: 12. Name Benjamin Long

13. Birthplace Md

MOTHER: 14. Maiden Name Laura V. Hessey

15. Birthplace Md

16 (a) Informant Gladys M. Coyroades

(b) Address 508 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1944 (month) (day) (year)

(c) Cemetery or crematory Pleasant Grove

Location Sandyville Md

18 (a) Funeral director Roff & B.M. Walter

(b) Address Pratt & Stricker Sts

19 JUL 31 1944 Huntington Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 12 03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to July 28 1944 and that I last saw h[illegible] alive on 7/28 1944

Immediate cause of death Carcinoma of breast — Duration 3 Mos

Due to

Due to

Other Conditions Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation May 1944

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ramsay S. Alexander M. D.

Address 336 Westland Date signed 7/29/44

G19428 107309 G19428

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 49a Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town TIMONIUM (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Timonium and Jenifer Rds. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Kaufman
3 (b) If veteran, name war No
3 (c) Social Security Account No. none
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Henry Kaufman
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) 1-18-87
8. AGE: Years 57 Months 6 Days 11 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housf.
11. Industry or business

FATHER
12. Name William Boucher
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Baker
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Cremation (b) Date thereof 8/1/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md
18 (a) Funeral director Gilbert Co Inc
(b) Address 219 E Fayette St
19 (a) JUL 31 1944 (Date rec'd by registrar) (b) Huntington Millington Md

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944 at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8- 1944 to 7-29 1944, and that I last saw her alive on 7-29 1944

Immediate cause of death Uremia — Duration 6 days

Due to Obstruction both ureters from recurrent

Due to Carcinoma ovary 2yrs after hysterectomy + tampul

Other Conditions both tubes + ovaries

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature David B. Cheek
Address Johns Hopkins Hospital Date signed 7/30/44

G19429 T.6.P.-89174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19429 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 North Fulton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Nicholtz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1860

8. AGE: Years	Months	Days	If less than one day
83	8	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

MOTHER / FATHER
12. Name John H. Dower
13. Birthplace Maryland
14. Maiden Name Catherine Ramsburg
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Removal - Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory Creagerstown Md.
Location

18 (a) Funeral director M. L. Creager & Son
(b) Address Thurmont Md.

19 (a) Filed Jul 31 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1944 19..., at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944, to 7-28 1944, and that I last saw her alive on 7/28 1944

Immediate cause of death	Duration
Bronchopneumonia	?
Due to Hypertension and cardiovascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address BCH Date signed 7/29/44

G19430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G19430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Kennith Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Kennith Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith M. Wieneke

3 (b) If veteran, name war W — 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21. 1894

8. AGE: Years 50 | Months 2 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Nashville Tenn
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Toney
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Lunsford
15. Birthplace Baltimore Md

16 (a) Informant Edward Wieneke
(b) Address 4812 Norwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Milton Gordon
(b) Address 1217 Eutaw St

19 JUL 31 1944 (Date rec'd by registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29- 1944, at 7 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-Vascular Renal Disease

Due to

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelis M.D.
Medical Examiner.
Date signed 7-30-44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92d

Registered No. G19431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband or ~~wife~~ Thos. Webb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20th 1866

8. AGE: Years 78 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John W. Ricks
13. Birthplace Md.

MOTHER
14. Maiden Name Clarissa Shipley
15. Birthplace Md.

16 (a) Informant Mrs Clara Morris
(b) Address 414 E. Cold Spring Lane

17 (a) Burial (b) Date thereof 8/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 317 St. Paul st.

19 (a) JUL 31 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29th 1944, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 7/29 1944 and that I last saw h. alive on 7/28 1944

Immediate cause of death: Chronic Interstitial Heart — Duration: Many Years
Due to: Arteriosclerosis
Due to:
Other Conditions: Cerebral arteriosclerosis — Duration: 6 Mos
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2020 N. Charles Date signed 7/29/44

G19432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G19432
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Martinsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Alice Whitmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23rd 1862

8. AGE: Years 82 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace London Co. Va
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Benard P. Whitmore
13. Birthplace London Co. Va.

MOTHER
14. Maiden Name Phoebe Ann Beach
15. Birthplace London Co. Va

16 (a) Informant Ann Beach L. Clark
(b) Address 2509 N. Charles ST

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)
(c) Cemetery or crematory Martinsburg
Location W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 Huntington Williams, Mgr.

JUL 31 1944
(Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29th 1944 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 29 1944 and that I last saw her alive on July 29 1944

Immediate cause of death Generalized Arteriosclerosis Duration Indef

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathaniel M Beck M.D.
Address 2727 N Charles Date signed July 29

G19433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

432

Registered No. G19433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3528 Lynchester Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3528 Lynchester Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: THOMAS A. DEAKINS, JR.

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 216-05-2243

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Deakins

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1/20/1889

8. AGE: Years: 55 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Teller

11. Industry or business: Rob't. Garrett & Sons

FATHER
12. Name: Thomas A. Deakins, Sr.
13. Birthplace: Md.

MOTHER
14. Maiden Name: Sallie C. Pumphrey
15. Birthplace: Md.

16 (a) Informant: Mrs. Mary E. Deakins
(b) Address: 3528 Lynchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

JUL 31 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1944, to 7-28 1944, and that I last saw him alive on 7-28 1944

Immediate cause of death	Duration
Cerebral hemorrhage -	1 dy.
Due to Arteriosclerosis -	
Due to Myocardial degeneration	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard F. Warren M. D.

Address 2664 Garrison Blvd. Date signed 7-29-44

G19434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G19434

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp. 46
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3622 Robert Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Robert Gallagher

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212 03 8381

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MILLIE GALLAGHER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7 1888

8. AGE: Years 56 3 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace GEORGIA (Town, county, and state)

10. Usual Occupation CONSTRUCTION IRON WORKER

11. Industry or business REVERE COPPER CO.

FATHER
12. Name MICHAEL GALLAGHER
13. Birthplace IRELAND

MOTHER
14. Maiden Name ELLEN GIBBONS
15. Birthplace GEORGIA

16 (a) Informant MILLIE GALLAGHER (WIFE)
(b) Address 3622 ROBERTS PLACE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 1/44 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lilly & Geiber Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) Huntington Williams, M.D.

JUL 31 1944

VS M

MEDICAL CERTIFICATION 30

20. DATE OF DEATH July 28 1944 at 4 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 52-00

(a) Date of injury 7/28/44 at James Stewart & Co. P M

(b) Where did injury occur? Baltimore, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes

(d) Means of injury Fell from scaffold

23. Signature H. L. Williamsberg M.D.
City Medical Examiner.

Date signed 7-29-44

G19435 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G19435

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fayette & Harlem Aves.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 1 hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John H. Gick
13. Birthplace

MOTHER 14. Maiden Name Edith Bailey
15. Birthplace N. Car.

16 (a) Informant John H. Gick
(b) Address Harlem & Lafayette Sts Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1944

(c) Cemetery or crematory Catholic
Location Balto. Md.

18 (a) Funeral director Geo. A. Little
(b) Address 2702 Edmondson Ave

19 (a) (Date received by local registrar) JUL 31 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1944, to 7-29 1944, and that I last saw h[illegible] alive on 7/29 1944.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Raffucci M.D. M. D.
Date signed 7/30/44
St Agnes Hosp.

T.C.P.-66146

G19436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44b

G19436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo. 4 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 721 S. Linwood Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Nores

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-2280

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30,1920

8. AGE: Years	Months	Days	If less than one day
24	1	28	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Fred Nores

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Mary ?

MOTHER 15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cemetery

Location German Hill Road

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson Street

19 (a) JUL 31 1944 (Date rec'd by registrar) (b)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1944 19 , at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1944, to 7-28 1944 and that I last saw him alive on 7-28 1944

Immediate cause of death Hodgkins disease

Due to

Due to

Other Conditions (over)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. C. Peery, Jr. M. D.

Address City Hosp. Date signed 7-31

G19437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

Registered No. G19437

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin D. Gerard Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald E. Mott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1922

8. AGE: Years 21 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Md.
(Town, county and state)

10. Usual Occupation Painter

11. Industry or business I.S.P.C.Co. Smith Ave

FATHER
12. Name George B. Mott
13. Birthplace Pa.

MOTHER
14. Maiden Name Edna R. Griffin
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 2505 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave.

18 (a) Funeral director A. Lamounta[illegible] Damon
(b) Address 3615-17 Chestnut Ave.

JUL 31 1944 (Date rec'd by registrar)

(c) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1944, at 8:10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning. Accidental.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-28-44 at 5:30 P M. 16/8
(b) Where did injury occur? Gwynns Falls Run off Edgewood Drive
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Accidental Drowning

23. Signature D. E. Wollam[illegible] M.D.
Medical Examiner.
Date signed July 29, 1944.

G19438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G19438

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-1933

8. AGE: Years	Months	Days	If less than one day
11	1	23	hr. min.

9. Birthplace Monroe, Virginia
(Town, county, and state)

10. Usual Occupation Student.

11. Industry or business

FATHER
12. Name Clifton Jones
13. Birthplace New York

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Va

16 (a) Informant Mrs Mary Jones
(b) Address 330 Bryant St. N.W. Wash. D.C.

17 (a) Burial (b) Date thereof 8-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md

18 (a) Funeral director Mr. Frances A. Henley
(b) Address 548 W. Biddle St

19 (a) (Registrar) (b) Huntington Md.

JUL 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1944 to July 29 1944, and that I last saw him alive on July 29 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo Banquer M. D.
Address Provident Hospital Date signed 7/30/44

G19439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19439
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 N. Charles Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vera ~~Beckwith~~ Bateman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Wheeling W. Va
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name William Henderson
13. Birthplace Wheeling W. Va

MOTHER
14. Maiden Name Mollie Martin
15. Birthplace Wheeling W. Va

16 (a) Informant Clarence Beckwith
(b) Address 1924 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-44 (month) (day) (year)

(c) Cemetery or crematory
Location Wheeling W. Va

18 (a) Funeral director Mrs. Frances B. Heisley
(b) Address 578 W. Biddle St
Huntington Williams, M.D.

19 (a) JUL 31 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29- 1944, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelis M.D.
Medical Examiner.
Date signed 7-30-44

(over)

VS 151

G19440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G19440

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Everett

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Norflat Everett.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1896

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Carter
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Homer Everett
(b) Address 555 Baker St

17 (a) Burial (b) Date thereof 8-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Gilead
Location Suffolk Va

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 578 W. Biddle St.
19 (Date received by registrar) JUL 31 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944 at 3:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1943 to July 28 1944 and that I last saw h.er alive on July 27 1944.

Immediate cause of death	Duration
Carcinoma of Uterus	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. K. Adams M. D.
Address 1222 N. Caroline Date signed July 31-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G19441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

G19441
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univerosity Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Dabney

3 (b) If veteran, name war —

3 (c) Social Security Account No 213-20-3622

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-1925

8. AGE: Years	Months	Days	If less than one day
18	7	7	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation steel worker

11. Industry or business

FATHER
12. Name Henry Dabney
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Nickens
15. Birthplace Va.

16 (a) Informant Martha Dabney
(b) Address 402 Pearl St.

17 (a) Burial (b) Date thereof 8/2/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Richmond
Location Va.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 Filed Jul 31 1944 Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30- 1944, at 12 10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of Heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-30- at 12.30 A M.
(b) Where did injury occur? Tavern - Pierce & Pearl Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm - automatic

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-30-44

G19442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ Registered No. G19442

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Grynkiewicz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25-1904

8. AGE: Years 40 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Szymanski
13. Birthplace Poland

MOTHER
14. Maiden Name Dora Lewandowski
15. Birthplace Poland

16 (a) Informant Edward Grykiewicz
(b) Address 2000 Eastern ave

17 (a) Burial (b) Date thereof 8-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) [illegible] Huntington Williams, M.D.
(Signature of local registrar) Registrar

JUL 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1944 to July 29 1944 and that I last saw h. alive on July 29 1944.

Immediate cause of death	Duration
Acute Cardiac dilatation	1 day
Due to Chronic Myocarditis	6 mos.
Due to	
Other Condition Cardiac Asthma	2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Szymanski M. D.
Address 1802 Eastern ave Date signed 7-31-44

G19443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G19443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 W Montgomery
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 W Montgomery (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Bunch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1861

8. AGE: Years 82 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Kent Neck Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER
12. Name Lead Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Susana Edridge
15. Birthplace Va

16 (a) Informant Lucretia Bunch
(b) Address 141 W Montgomery St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)
(c) Cemetery or crematory Norfolk Va
Location

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

19 (a) [illegible] (b) JUL 31 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944 at 12:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1944 to 7/30 1944 and that I last saw her alive on 7/29 1944.

Immediate cause of death: Lobar Pneumonia 2 da — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Eichelcomb M. D.
Address 1131 Harlem Ave Date signed 7/31/44

G19444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G19444 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 Lehmans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elise Gauger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife late Richard H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1870

8. AGE: Years 73 | Months 72 | Days 9 | 11 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Kisler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Paul Gauger
(b) Address 2636 Lehman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry W. Wetzke
(b) Address 4101 Edmondson Ave

19 JUL 31 1944 (Date received by Local Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1944, at 2:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 7/28/44

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 ✓

Registered No. G19445

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 wd.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Glyndon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KEIRLE, VINCENT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1944

8. AGE: Years | Months: 2 | Days: 24 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name William Keirle
13. Birthplace Balto

MOTHER
14. Maiden Name Ruth Arnold
15. Birthplace Balto

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location

18 (a) Funeral director Joseph Kaminskas Jr
(b) Address 602 Washington Blvd

19 (a) (Date rec'd by local registrar) (b) Huntington Williams, M.D.

JUL 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1944, to 7-30 1944, and that I last saw h[illegible] alive on 7-30 1944.

	Duration
Immediate cause of death: respiratory failure	
Due to: Bronchopneumonia	3 d.?
Due to: Pertussis	10 days
Other Conditions: diarrhea & acidosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 7-30-44

G19446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 1 C

Registered No. G19446

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Kentucky Ave.
(c) Hospital or institution:

8 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Kentucky Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES BERGNER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Birkenstock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1860

8. AGE: Years	Months	Days	If less than one day
84	0	8	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frederick Bergner
13. Birthplace Germany

MOTHER
14. Maiden Name Anna R. Vagge
15. Birthplace Germany

16 (a) Informant Mrs. Charles Bergner
(b) Address 2224 Kentucky Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meamston
(b) Address 805 N. Calvert St.,

19 (a) (b)

JUL 31 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 2.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1940 to July 29 1944 and that I last saw h[illegible] alive on July 29 1944

Immediate cause of death	Duration
Tb Pulmonary	16 Yrs
Due to Arterio Sclerosis	4 yrs
Due to Senile Paralysis agitans	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Thomas M. D.
Address 3136 Harford Rd Date signed July 29 1944

G19447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G19447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hennig Everett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charlotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 15 1869

8. AGE: Years 75 | Months - | Days 15 | If less than one day ... hr. ... min.

9. Birthplace: Elkins W. Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Jireh Everett
13. Birthplace: Randolph Co. W. Virginia

MOTHER
14. Maiden Name: Fredricke Ann
15. Birthplace: Randolph Co. W. Virginia

16 (a) Informant: Son. Fred Everett
(b) Address: 1108 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 2/44 (month) (day) (year)
(c) Cemetery or crematory: Gilmens W. Virginia
Location: Elkins W. Virginia

18 (a) Funeral director: Frank Della Vode
(b) Address: 52 N. Monty St.

(a) JUL 31 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1944, at 1.20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Hugh B. McNally M.D. Medical Examiner.
Date signed 7/30/44

9448 BALTIMORE CITY HEALTH DEPARTMENT G19448

CERTIFICATE OF DEATH 186V Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia H. VENEZIANO

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-24-5576

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph L.

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1919

8. AGE: Years	Months	Days	If less than one day
24 25	7	27	hr. min.

9. Birthplace Columbia N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel N. Floyd
13. Birthplace Ala

MOTHER
14. Maiden Name Orpie Herring
15. Birthplace N.C.

16 (a) Informant Mr Joseph L. Veneziano
(b) Address 1923 St. Paul St.

17 (a) Burial (b) Date thereof Aug 1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 1530 Harford Rd.

JUL 31 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944 at 8:27 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/28/44 at 1 P.M.
(b) Where did injury occur? 805 E. Baltimore St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fell out of 3rd story Window

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed July 29, 1944

Over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

310

Registered No. G19449

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Ostend St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Walter W. Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			..... hr. ..... min.

9. Birthplace Towson, Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Isaac Robinson
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Maggie Bayer
15. Birthplace Harford Co Md.

16 (a) Informant Anna K. Robinson
(b) Address 817 N. Ostend St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 31, 1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Md.

18 (a) Funeral director Wm Gen. H. Holland
(b) Address 1631 Druid Hill Ave
(c) Jul 31 1944 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28- 1944, at 12 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Cardio-vascular Renal Disease

Due to.....

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Andersen M.D. Medical Examiner.
Date signed 7-28-44

VS 151

G19450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310

G19450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 E. Chase St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 E. Chase St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret S. Naas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John H. Naas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1857

8. AGE: Years	Months	Days	If less than one day
87	5	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Winkelman
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Georg
15. Birthplace Germany

16 (a) Informant Marie N. Hammond
(b) Address 210 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Windsor Mill Road, City

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 JUL 31 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 19 44 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to 7-28-1944 and that I last saw h[illegible] alive on 7-28 1944.

Immediate cause of death Cerebral Hemorrhage - | Duration 3 days
Due to Hypertension - | years
Due to Arteriosclerosis Chronic Nephritis. | years
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Seward M. D.
Address Medical Arts Bldg. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS 180

G19451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1936

Registered No. G19451

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St Joseph's Hospital

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 66 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 821 N. 34th Street (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Crescentia Molz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Otto Molz,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6. 1858

8. AGE: Years 86 Months 6 Days 28 If less than one day hr. min.

9. Birthplace Germany (City, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Jacob Heininger

13. Birthplace Germany

MOTHER 14. Maiden Name Crescentia Krones

15. Birthplace Germany

16 (a) Informant Joseph Molz

(b) Address 1617 Purdue Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18 (a) Funeral director Durbee Funeral Home

(b) Address 3631 Falls Road.

19 (Date received by registrar) JUL 31 1944 Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944, at 4.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1944 to 7-31 1944, and that I last saw her alive on 7-30 1944.

Immediate cause of death Hypostatic pneumonia

Due to Arteriosclerotic C.V. disease & bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 7-31-44

G19452

T.C.P.-89141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G19452 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 West 42nd Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Matthews

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward P. Matthews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14 1870

8. AGE: Years 74 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business --

FATHER
12. Name Richard Martin (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Robinson (d)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Saters
Location Baltimore Co.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Rd

19 Date received by Local Registrar JUL 31 1944 Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1944 19 , at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24- 1944 to 7-29 1944 and that I last saw h[illegible] alive on 7-29- 1944

Immediate cause of death: Diabetes & Gangrene — Duration 9 yrs.

Due to: Uremia

Due to:

Other Conditions: Cardio-renal disease
(Include pregnancy within 3 months of death)

Date of operation 7-26-44

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? — — — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature S. P. Nasaro M. D.
Address 4940 Eastern Ave Date signed 7-30-44

G19453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19453 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 4703 Hamptrette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3642 Old York Road (Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nancy Elizabeth McGee

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color of race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James F. McGee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1876

8. AGE: Years 68 | Months 2 | Days 3 | If less than one day: hr. min

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ryan
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Powell
15. Birthplace Ireland

16 (a) Informant James Harry McGee
(b) Address 3642 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Md.

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road

19 (a) Received by (Registrar) (b) Huntington Williams, M.D. Registrar

JUL 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 6-P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to July 29 1944, and that I last saw her alive on July 29 1944.

Immediate cause of death: Cerebral Hemorrage — Duration: 4 mos
Due to: Hypertension CVD — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Shumaker M. D.
Address 3711 Falls Rd Date signed 7-30-44

G19454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G19454 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Appleby Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 12 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Appleby Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Hyman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11-1856

8. AGE: Years 88 | Months — | Days 18 | If less than one day hr. min

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Jackson Hyman
13. Birthplace Maryland

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Charles H. Stuller
(b) Address 1303 Appleby Avenue

17 (a) Burial (b) Date thereof July 31-1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2431 Falls Road

19 (a) JUL 31 1944 (Date filed by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 1.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 8th 1939 to July 29th 1944 and that I last saw he alive on July 29th 1944

Immediate cause of death: Carcinoma of Ovary — Duration 2 yrs.
Due to:
Due to:
Other Conditions Art. Sclerosis, Chronic Myocarditis — 5 yrs, 2 yrs.
(Include pregnancy within 3 months of death)
Date of operation April 1943
Major findings of operation: Carcinoma of ovary
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jane A. Miller M.D.
Address Pikesville, Md. Date signed 7/30/44

VS 150

G19455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

G19455

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No Box 168 Route 3 Fisher Road (If rural give location)
Balto 22
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: black

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years: 16 | Months | Days | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Carl Fleming
13. Birthplace Va

MOTHER
14. Maiden Name Amy Breton
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 31 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond Virginia

18 (a) Funeral director Mrs. Lotet O. Elliott Dft.
(b) Address 129 N. Carolina St.

19 JUL 31 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944 at 6 07 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Respiratory failure — Duration

Due to: Pulmonary tuberculosis

Due to: Bilateral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Date signed 7-29-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19456

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Ber | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-03

8. AGE: Years 40 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jo Witherspoon
13. Birthplace (N.C.)

MOTHER 14. Maiden Name Carrie Thompson
15. Birthplace (N.C.)

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location G.G. County Md.

18 (a) Funeral director Mr. Lobert Hellbrun
(b) Address 1129 N. Caroline St

19 (a) Filed JUL 31 1944 (Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28- 1944 at 9 46 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20- 1944 to 7-28- 1944 and that I last saw her alive on 7-28- 1944.

Immediate cause of death Renal insufficiency — Duration

Due to Chronic nephritis

Due to

Other Conditions ? toxic hepatitis
? cholelithiasis or cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. S. Perrin M. D.
Address Johns Hopkins Hosp Date signed 7 28

C19457442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. C19457

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 N Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: black

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emma Hill

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? ? 86 (?)

8. AGE: Years 58 (?) Months Days If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer, Coal Op. Sparrows Point

11. Industry or business

FATHER
12. Name John Hill
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs. Robert G. Elliott & Dyer
(b) Address 1129 N. Caroline St.

19 (a) JUL 31 1944 (b) Registrar
Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944 at 3 55- P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1944, to 7-30 1944, and that I last saw him alive on 7-30- 1944.

Immediate cause of death: Respiratory Faiture — Duration: 9 days

Due to: Coronary occlusion — 4 days

Due to: Lobar pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Eberhart M.D.
Address Johns Hopkins Hosp. Date signed 8-3-44

G19158 ~~19152~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1831

Registered No. G19458

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 N Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mabel Smith

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 3-15-89

8. AGE: Years 55 | Months 4 | Days 15 | If less than one day ..... hr. ..... min.

9a. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Edgewood

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace S.C.

MOTHER
14. Maiden Name Eda Earl
15. Birthplace S.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Aug 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. G. County Md.

18 (a) Funeral director Mrs. Peter A. Ellis & Son
(b) Address 1229 N. Carlton St

19 JUL 31 1944 Registered by [illegible] for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12-1944 to 7-30 1944 and that I last saw him alive on 7-30 1944.

Immediate cause of death Cerebral Thrombosis — Duration 1 week

Due to Arterial Sclerosis — 5 yrs ?

Due to

Other Conditions Multiple Arterial Thrombi, Hemiplegia — 2 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Longmire Jr., M.D.
Address Johns Hopkins Hosp, Date signed 7/30/44

Dr Berry E. Chase Sr

G19459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G19459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1760 Llewelyn ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1760 Llewelyn ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lombard Dunaway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1891

8. AGE: Years 53 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Richmond Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Dunaway
13. Birthplace Va

MOTHER 14. Maiden Name Celeia Dunaway
15. Birthplace Va

16 (a) Informant Virginia Warren
(b) Address 1760 Llewelyn ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 31-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 JUL 31 1944 Hampton Williams, M.D. Registrar
(Date of city registration)

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944 to July 28 1944 and that I last saw him alive on July 28 1944

Immediate cause of death Acute myocarditis
Uremia

Due to Cerebral Apoplexy

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 Day
3 Days
6 Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Roy Berry M. D.

Address 1420 E. Chase Date signed 7-31-44

G19460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G19460
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 966 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy J. Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced 218-07-3584

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/12

8. AGE: Years 32 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Simpson
13. Birthplace Va

MOTHER 14. Maiden Name Annie Brooks
15. Birthplace Va

16 (a) Informant Summie Simpson
(b) Address 820 Ruttenber Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Percy Williams
(b) Address 516 Mordecai Ave

19 (a) JUL 31 1944 (Date rec'd by Registrar) Huntington Williams, M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 44; at 3A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumonia Lobar, Collateral.

Due to

Other Conditions Hypertensive cardio-vascular disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed July 27, 1944

VS 151

G19461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193d

G19461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 815
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Lane

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-2819

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1894

8. AGE: Years 50 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation motorman Balto. Transit

11. Industry or business

FATHER
12. Name Benj. Lane
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Alberta McManus
15. Birthplace Balto., Md.

16 (a) Informant Dorothy Lane
(b) Address 1814 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 '44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Rural

18. (a) Funeral director Welsh Funeral Home
(b) Address 2004 E. Orleans St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1944 at 12 P.M. 45

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenweber M.D.
Medical Examiner.
Date signed 7-31-44

VS 151

G19462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mos

2. USUAL RESIDENCE OF DECEASED
(a) State Md.
(b) City or town Balto. County
(c) Street No. 2621 Old Joppa Road
(d) Citizen of foreign country? If yes, name country

3 (a) FULL NAME Robert Grove

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/26/93

8. AGE: Years 1 | Months 10 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles Grove
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Emma Rassel
15. Birthplace Maryland

16 (a) Informant Charles Grove
(b) Address 2621 Old Joppa Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-94 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto Co. Md

18 (a) Funeral director L. L. Pugh
(b) Address 5305 Harford Rd. Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md Registrar

VR 110 JUL 31 1894

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31-94

21. I certify that death occurred on the date above stated, that I attended deceased from 7-26-94 to 7-31-94 and that I last saw him alive on 7-31-94

Immediate cause of death Lung failure

Due to Tuberculous empyema

Due to —

Other Conditions —

Date of operation —

Major findings of operation —

of autopsy —

PHYSICIAN

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Peterson M. D.
Address University Hospital Date signed 7-31-94

G19463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19463 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Garrison Ave.
(c) Hospital or Institution: Mrs Schaeffer's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. about 519 Park Ave (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Helen Gordon

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 1866

8. AGE: Years 78 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Josiah Hans Gordon
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden Name Katherine Umbaugh
15. Birthplace Shawsdon Md.

16 (a) Informant Mrs Martha G. Harris (sister)
(b) Address Dickerson Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 44 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland Md.

18 (a) Funeral director Edward Mongello.
(b) Address 108 N Monroe St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 31 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 19 44 at 12.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3, 1944 to July 30, 1944, and that I last saw her alive on July 30, 1944

Immediate cause of death: Chronic Myocarditis — Duration: 1 year.
Due to —
Due to —
Other Conditions: Blind, Chronic Cholecystitis (Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: none
of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank K. Ogburn M. D.
Address 2701 N. Calvert St Date signed July 31 1944

G19464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19464 Registered No. 1223

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves.
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town) 2804 Raynor Ave. Balto.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Madora Bacon

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-22-8024

4. Sex: Female

5. Color or race: W. Cristo

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas Bacon, Jr.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12 1871

8. AGE: Years 73 | Months 5 | Days 18 | If less than one day: hr. min.

9. Birthplace: Maryland (Balto.) (Town, county, and state)

10. Usual Occupation: Seamstress

11. Industry or business:

FATHER
12. Name: Henry C. Beard
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Lavinia Ellen Evans
15. Birthplace: Baltimore, Md.

16 (a) Informant: Miss Margaret Badger
(b) Address: 4 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 31 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944, to 7-30 1944, and that I last saw h[illegible] alive on 7-30 1944

Immediate cause of death: Emaciation — Duration:

Due to: Chronic cholecystitis, Pericholecystic abscess, chronic pleuritis, partial intestinal obstruction

Other Conditions: senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Partial intestinal obstruction

of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Stiles, M.D.

Address St Agnes Hosp. Date signed 7-30-44

G19465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G19465 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Everett Joy (Everett James Joy)

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elsie Mae
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1889

8. AGE: Years 55 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Hollywood, St. Mary's Co., Md. (Town, county, and state)

10. Usual Occupation Pumper

11. Industry or business Baugh Chemical Co.

FATHER
12. Name Everett Joy
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16. (a) Informant Mrs. Elsie Joy
(b) Address 1513 N. Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Huntington Williams

19 (a) JUL 31 1944 (Date rec'd by registrar) (b) Registrar

VS 161

MEDICAL CERTIFICATION 2a

20. DATE OF DEATH July 30, 1944, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Valvular heart disease
Cardiac stenosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature H. L. Kallenmeyer M.D.
Medical Examiner.
Date signed 7-31-44

G19466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19466 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 N. Hilton Rd.

(c) Hospital or institution: Ashburton Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3526 N. Hilton Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carrie L. Krimmel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife John G. Krimmel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1867

8. AGE: Years 76 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name William King

13. Birthplace Germany

14. Maiden Name Susan Ostewald

15. Birthplace Md.

16 (a) Informant Mrs. J. G. Krimmel

(b) Address 3526 N. Hilton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem. Location Pikesville, Md.

18 (a) Funeral director Wm. J. Fickus & Son

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 10 JUL 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1944 at 9.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to July 28 1944 and that I last saw h. alive on July 28, 1944

Immediate cause of death: Bronchopneumonia (terminal) — Duration 1 day

Due to Myocardial Insufficiency

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sidney D. Levy M.D.

Address 2322 Eastern Ave Date signed 8/1/44

G19467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G19467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 W. Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah ALLEN NICHOLS

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-2234

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Howard Nichols
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1903

8. AGE: Years	Months	Days	If less than one day
40 41	7	5	hr. min.

9. Birthplace Florence, S. C. (Town, county, and state)
10. Usual Occupation Factory Worker
11. Industry or business

FATHER
12. Name John [illegible] Laney
13. Birthplace S.C.

MOTHER
14. Maiden Name Ropey ? Stephenson
15. Birthplace S.C.

16 (a) Informant Howard Nichols
(b) Address 737 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie B. Walker
(b) Address 322 N Schroeder St

19 (a) JUL 31 1944 (Date received by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1944, at 4.30 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Knight H. McHall M.D. Medical Examiner.
Date signed 7/30/44

G19468 Frey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19468 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 Sarah Ann
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Sarah Ann (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Nora Noah Frey

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lizzie Frey

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar 13/67

8. AGE: Years 77 Months 4 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name David Frey
13. Birthplace Md

MOTHER 14. Maiden Name Maria
15. Birthplace

16 (a) Informant Lizzie Frey
(b) Address 1110 Sarah Ann

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Nettie R. Williams

(b) Address 322 N Fulton Ave

19 (a) JUL 31 1944 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944, to July 29 1944, and that I last saw him alive on July 28/44

Immediate cause of death Hemorrhage

Due to Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature David E. Wagner

Address 2027 Seabury Ave

7/31/44

VS 3

G19469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G19469 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira + Linden
(c) Hospital or institution:
Md Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 So. Exeter
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John T Mc Mahon

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	S

6 (b) Name of husband or wife *
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR 15-1865

8. AGE: Years	Months	Days	If less than one day
79	4	15	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Marvin Mc Mahon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dunn
15. Birthplace Ireland

16 (a) Informant Michael J. Mc Mahon
(b) Address 320 S. Exeter Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG. 3- 44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans + Son
(b) Address 4th Maryland Ave

JUL 31 1944

19 (a) (b) Huntington Williamsport Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 1944, at 6 3/4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1944 to 7-30 1944.
and that I last saw h alive on 7-30 1944.

Immediate cause of death	Duration
Senile cachexia	
Due to chronic ulceration left leg	
Due to old age	
Other Conditions arteriosclerosis far advanced. + Amputation at leg.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 7-31-44

VS 150

G19470 BALTIMORE CITY HEALTH DEPARTMENT G19470

CERTIFICATE OF DEATH 93E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 24 (If outside city or town limits, write RURAL and give town)
(d) Street No 3822 Hudson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Irene Evans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Geo. D. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/21/89

8. AGE: Years 55 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John ~~Lawrence~~ Law
13. Birthplace Maryland

MOTHER 14. Maiden Name Catherine Steinem
15. Birthplace Md.

16 (a) Informant Husband
(b) Address 3822 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway, City

19 (a) (Date received by registrar) Huntington Williams, M.D. JUL 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1944, at 6-20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1944 to 7/28 1944 and that I last saw her alive on 7/28 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Congestive Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. A. Crosby
Address Mercy Hosp. Date signed 7/28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G19471

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution Maryland Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre De Grace Md (If outside city or town limits, write RURAL and give town) Rural
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George M Standiford
3 (b) If veteran, name war Mr
3 (c) Social Security Account No. Mr

4. Sex 62 | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nellie S Standiford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Harford Co Maryland (Town, county, and state)

10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Wm A
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E
15. Birthplace Md

16 (a) Informant H B Bailey
(b) Address Darlington, Md

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Aug 3 1944 (month) (day) (year)
(c) Cemetery or crematory Rock Run Cem
Location Harford Co Md

18 (a) Funeral director H B Bailey
(b) Address Darlington, Md

AUG 31 1944 (Date rec'd by registrar) Huntingtown Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 1944 at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1944 to 7-31 1944 and that I last saw h[illegible] alive on 7-31 1944

Immediate cause of death Coronary Occlusion / failure — Duration 1 mo

Due to General debility

Due to Hypostatic pneumonia / probably

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-6-44 7-22-44

Major findings of operation: Left Kidney removed

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo B Talley Jr
Address Maryland Genl Hosp Date signed 7-31-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 186

G19472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1120a

G19472
Registered No.

MARGIN RESERVED FOR BINDING

* PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Reilley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace St Louis Mo. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Reilley
13. Birthplace Ireland

MOTHER
14. Maiden Name Josephine Beahey
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1. 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 914 Communidad Ave

19 (a) (Signature of registrar) (b) Huntington Williams M.D.

JUL 31 1944

MEDICAL CERTIFICATION 9 a.m.

20. DATE OF DEATH July 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944 July 29 1944, and that I last saw h. alive on 7/29 1944.

Immediate cause of death Cerebral Coma — Duration 5 days
Due to Thr Diabetes
Due to Chr Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation none
*Major findings of operation: X XXX
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence XXXX at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? XXXX (Specify type of place) While at work?
(e) Means of injury

Signature Otto H. Duke M. D.
Address 928 E. North Ave Signed 7/31/44

G19473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9

G19473

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 732 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 W Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Elson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1944

8. AGE: Years | Months: 3 | Days: 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Nelson
13. Birthplace Md

MOTHER
14. Maiden Name Mildred Stonaker
15. Birthplace Md

16 (a) Informant Harry Nelson
(b) Address 732 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)
(c) Cemetery or crematory St Mary
Location Norwood Dulto Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1317 E Lombard St

19 (a) AUG 1 - 1944 Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1944 to July 29 1944, and that I last saw h alive on July 29 1944.

Immediate cause of death ?

	Duration
Due to WHOOPING COUGH	3 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy F. McCa
Address 2622 Washington Blvd Date signed 7/31/44 M. D.

G19474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19474
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution:
Aged Home of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Shipley

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1850

8. AGE: Years 94 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Hammond Shipley
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Susan Fitz
15. Birthplace Baltimore Co Md

16 (a) Informant Minnie Yates
(b) Address 2211 Rogers Ave

17 (a) Burial (b) Date thereof 8/1/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Tilthom Cook Inc
(b) Address 1217 E Fayette St

AUG 1 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 29 1944, and that I last saw h[illegible] alive on July 29 1944.

	Duration
Immediate cause of death: Myocardial Insufficiency	4 days
Due to: Arterio Sclerosis	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 800 W 39th St Date signed 7-31-44

VS. 180

G19475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1176 ✓ Registered No. G19475

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — University Hospital
(b) Street address — Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 10
(e) Length of stay in Baltimore (yrs., mos., or days) — 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md (b) County
(c) City or town — Baltimore - 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 933 Webb Court
(If rural give location)
(e) Citizen of foreign country? — no (Yes or No)
If yes, name country

3 (a) FULL NAME — Mrs Charlotte DeVos

3 (b) If veteran, name war — —
3 (c) Social Security Account No. —

4. Sex — F
5. Color or race — W
6 (a) Single, married, widowed, or divorced. — ~~Married~~ Widowed
6 (b) Name of husband or wife — William J. DeVos dead
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) — Feb 23rd 1881
8. AGE: Years — 63 | Months — 5 | Days — 7 | If less than one day — hr. — min.
9. Birthplace — England (Town, county, and state)
10. Usual Occupation — At Home
11. Industry or business — Self

FATHER
12. Name — (Unknown)
13. Birthplace — England

MOTHER
14. Maiden Name — Sarah (Unknown)
15. Birthplace — England

16 (a) Informant — Charlotte A. DeVos
(b) Address — 933 Webb Court
17 (a) Burial — (b) Date thereof — 8/2/44 (month) (day) (year)
(Burial, ~~cremation~~, or removal)
(c) Cemetery ~~or crematory~~ — Loudon Park
Location — Balto. Md.
18 (a) Funeral director — William Cook Inc
Address — 317 St. Paul St
19 (a) — Huntington Williams, Hyde
(Date rec'd by registrar) AUG 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH — July 30, 1944, at 9-29 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1944, to 7-30 1944, and that I last saw her alive on 7-30 1944.

Immediate cause of death	Duration
Diabetic coma	
Possible peritonitis	
Due to Sub-total gastrectomy	
Due to Duodenal ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation — 7-24-44
Major findings of operation: Duodenal ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature — I. W. Tilt Jr. M. D.
Address — University Hospital — Date signed 7-30-44

G19476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No. G19476

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 558 N. Bay St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charles D. Berger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Clara La Bahn
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 7th 1887

8. AGE: Years 57 | Months 3 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Window Washer.

FATHER
12. Name Albert M. Berger
13. Birthplace Buffalo, N.Y.

MOTHER
14. Maiden Name Florence Ayers
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Clara Berger
(b) Address 2317 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1st 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md. AA Co.

18 (a) Funeral director Earl F. Thees
(b) Address 915 Light St.

19 (a) AUG 1 - 1944 (Date rec'd by registrar) [illegible] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1944 at 12-10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1944 to 7/29 1944 and that I last saw h[illegible] alive on 7/29 1944

Immediate cause of death Uremia — Duration
Due to Hyp. C.V.D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas D Lusby M.D.
Address Fr. Sq. Hosp. Date signed 7/29/1944

19477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19477

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Fairbank Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Fairbank Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROWLAND K. ADAMS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	19	hr. min.

9. Birthplace Waynesboro, Pa.
(Town, county, and state)

10. Usual Occupation Judge of Court of Appeals
11. Industry or business of Maryland

FATHER
12. Name Joseph C. Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Keedy
15. Birthplace Md.

16 (a) Informant Mrs. Elva Adams
(b) Address 1808 Fairbank Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Filed AUG 1 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 29, 1944, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1943, to July 29 1944, and that I last saw h[illegible] alive on July 29 1944.

Immediate cause of death: Tuberculosis, Respiratory failure — Duration 6 months.

Due to arteriosclerosis. — Duration 1 yr.

Due to Spinal Cord. — Duration

Other Conditions: progressive.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. O'Hara M.D.
M. D.
Address 504 Cathedral St. Date signed 7/31/44

G19478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

924

Registered No. G19478

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 318 E. 20th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 318 E. 20th St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA HAESLOOP

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Adolph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1860

8. AGE: Years	Months	Days	If less than one day
83	10	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Frederick Schindhelm

13. Birthplace Germany

MOTHER — 14. Maiden Name Catherine Saitz

15. Birthplace Balto., Md.

16 (a) Informant Mr. Eugene E. Hoopes, 3rd

(b) Address 318 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received by Local Registrar AUG 1 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1944, at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944 to July 29 1944, and that I last saw her alive on July 29 1944.

Immediate cause of death: Chr. Valvular Heart — Duration: 2 yrs

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Howard Hoffman M.D.

Address 2020 N. Charles Date signed 7/31/44

G19479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1640 Registered No. G19479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bayview Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town N.Y.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 97 W. 123rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H. Byrne

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/17/44 (month) (day) (year)

(c) Cemetery or crematory New York, N.Y.

Location UNIVERSITY MEDICAL SCHOOL JUL 31 1944

18 (a) Funeral director

(b) Address 4644 [illegible]

AUG 1 1944 Hunterdon Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21- 1944, at 9 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-21-44 at 9.45 P.M.

(b) Where did injury occur? S.W. Station House

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Hanging from cell door - self inf

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 7-22-44

2046

G19480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-9

Registered No. G19480

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos. 26 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mos. 26 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4107 Newton Ave. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Baby Boy Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 6, 1944

8. AGE: Years | Months: 2 | Days: 26 | If less than one day: ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER — 12. Name Arthur P. Henderson

13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Mabel Brown

15. Birthplace Demings, Md.

16 (a) Informant.....

(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL JUL 31 1944

Location

18 (a) Funeral director Commissioner of Health

(b) Address.....

19 (Date rec'd by registrar) AUG 1 1944 (Signature of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1944, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Before 19 to In Service 19, and that I last saw h alive on 19.

Immediate cause of death: Pneumonia

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Palmer M. D.

Address University Hospital Date signed 7-30 '44

VS 150

2045

G19481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159 V

G19481 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Parkville Premature infant Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Sinclair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carback

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-'44

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace Not Known

MOTHER 14. Maiden Name Virginia

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or Location UNIVERSITY MEDICAL SCHOOL JUL 31 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 AUG 1 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1944, at 9-05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 1944, and that I last saw h alive on 1944.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Palmason M. D.

Address University Hospital Date signed 7-30

2044

G19482

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 59

Registered No. G19482

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale + Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 378 E. Mary St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/18/44

8. AGE: Years | Months | Days | If less than one day 6 hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business —

FATHER
12. Name Edward Jackson
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Young
15. Birthplace Batesburg, Md

16 (a) Informant Edna Jackson
(b) Address 378 E. Mary St.

17 (a) — (Burial, cremation, or removal) (b) Date thereof — (month) (day) (year)

(c) Cemetery or crematory —
Location UNIVERSITY MEDICAL SCHOOL JUL 31 1944

18 (a) Funeral director Commissioner of Health
(b) Address —

19 (a) AUG 1 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1944, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1944, to 7/18 1944, and that I last saw h. l. M. alive on 7/18 1944.

Immediate cause of death Resp. Failure — Duration 6 hrs

Due to Prematurity — 6 hrs

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Robert T. Nelson

Address University Hospital Date signed 7/18/44

VS 150

2043

G19483

Jo #68060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 b

G19483

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1808 Aisquith St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine Alethia King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1921

8. AGE: Years 22 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Benjamin Meekins

13. Birthplace Maryland

14. Maiden Name Etta Jennifer

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/44 (month) (day) (year)

(c) Cemetery or crematory Taylor Island Md

Location

18 (a) Funeral director Joseph B. Locke

(b) Address 1364 N. Central Ave

19 (a) (b) Huntington Williams Registrar

(Date received by registrar) AUG 1 - 1944

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1944, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17, 1944, to July 29, 1944, and that I last saw her alive on July 29, 1944.

Immediate cause of death pulmonary tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Perry M. D.

Address City Hosp. Date signed 7-30

G19484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G19484
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Chamhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 Riverside Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Glaser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife John Glaser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 1872

8. AGE: Years 71 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name unknown
13. Birthplace "

MOTHER: 14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Ignatius Bayline
(b) Address 227 Riverside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Fred. A. Kramer & Son
(b) Address 216 N. Charles St

19 (a) (b)

AUG 1 1944
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1944, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1944 to 7-29 1944 and that I last saw h[illegible] alive on 7-14 1944.

Immediate cause of death	Duration
Pneumonia bronchial	
Due to generalized	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sam'l Rubin M. D.
Address 203 Bulopan Ave. Date signed

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G19485

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Grinder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Swift
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-44

8. AGE: Years	Months	Days	If less than one day
	1/12	15	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name William Swift
13. Birthplace Ga

MOTHER
14. Maiden Name Mary Dickson
15. Birthplace Ga

16 (a) Informant Wm Swift
(b) Address 1324 Grinder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a a. co Md

18 (a) Funeral director James A Davis
(b) Address 142 W Pratt St

19 (a) Date received AUG 1 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944, at 7 01 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1944, to July 30 1944, and that I last saw [illegible] alive on July 30 1944.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Bagwell M. D.
Address Provident Hospital Date signed 7/31/44

G19486 ✓ G19486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 M Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hour

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Fawcett Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Helfer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/22/44

8. AGE: Years | Months | Days | If less than one day: One hr. 0 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Helfer
13. Birthplace

MOTHER 14. Maiden Name Sanders
15. Birthplace Baltimore, Md

16 (a) Informant Mother
(b) Address 422 Fawcett Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 31 1944

18 (a) Funeral director Commissioner of Health
(b) Address

1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22/44 19 , at 6.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22/44 19 , to 7/22/44 19 , and that I last saw h/m alive on 7/22/44 19 .

Immediate cause of death: Congenital Absence of Left Diaphragm — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Absence of Left Diaphragm

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gustavus Blessle M. D.
Address Franklin Square Hosp. Date signed 7/22/44

2052

G19487 X V G19487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH Pine Crest Home 9HW Registered No.

CITY OF BALTIMORE: (No. 600 S. Chapel Gate, St. | 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..yrs..mos..ds. How long in U. S. If of foreign birth? ..yrs..mos..ds.

2. FULL NAME John Wm. Myers V

(a) Residence: No. Edmondson Ave. - Catonsville St., Ward. Baltimore
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. Sex: Male | 4. Color or Race: White | 5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed or divorced HUSBAND of (or) WIFE of: Late May Moyer

6. DATE OF BIRTH (month, day, year): Sept 20-1862

7. AGE: Years 81 | Months 10 | Days 10 | If LESS than 1 day, ..hrs. or ..min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Manager of Realty Dept

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Maryland

FATHER

13. NAME: Myers

14. BIRTHPLACE (city or town) (State or country): Unknown

MOTHER

15. MAIDEN NAME: unknown

16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT (Address): Jos. Frank Myers 709 Park Ave

18. BURIAL, CREMATION, OR REMOVAL. Place: Cathedral Cem. Date: 8/2/44 19

19. UNDERTAKER: John R Kenny-
(Address) 1322 Eutaw Pl. Baltimore, Md.

20. AUG 1 - 1944 19 Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): July 30, 1944

22. I HEREBY CERTIFY, That I attended deceased from July 12, 1944 to July 30, 1944

I last saw him alive on July 30, 1944 Death is said to have occurred on the date stated above, at ..m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocardial Insufficiency	Today
Arterio Sclerosis with senile dementia	3 Yrs

Other contributory causes of importance:

Name of operation: Date of

What test confirmed diagnosis? Autopsy? Were there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. D.

(Address) 3326 Wilkens Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G19188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G19488

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vernon Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Black	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-31

8. AGE: Years	Months	Days	If less than one day
12	8	23	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vernon Jackson
13. Birthplace (Md)

MOTHER
14. Maiden Name Anna Williams
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 2, 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Md

18 (a) Funeral director George S. Nelson
Address 1 Preston St

AUG 1 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29- 1944, at 5-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8-29 1944 to 7-29 1944 and that I last saw h alive on 7-29 1944.

Immediate cause of death	Duration
Wound infection, fecal fistula (Hugh Stanley Cooke)	
Due to Operation for mega colon (total Colectomy)	
Due to Mega colon, congenital	Life
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/9/10 - (21) 7/8/44

Major findings of operation: (21) Stenosis

of autopsy: Diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Longmire Jr., M.D.
Address Johns Hopkins Hosp. Date signed 7/30/44

G19489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G19489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Riggs Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Riggs Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife John W. Williams
6 (c) If alive, give age 7 years
7. Birth date of deceased (mo., day, yr.) Dec. 26, 1889
8. AGE: Years 54 Months 7 Days 3 If less than one day hr. min.
9. Birthplace N. C. (town, county, and state)
10. Usual Occupation Private Family
11. Industry or business Laundry
FATHER 12. Name Sandy Elkins
13. Birthplace N. C.
MOTHER 14. Maiden Name Nancy Kearney
15. Birthplace N. C.
16 (a) Informant John W. Williams
(b) Address 706 Riggs Av
17 (a) (Burial, cremation, or removal) (b) Date thereof Aug. 2. 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md
18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.
19 AUG 1 - 1944 (b) Huddington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944 at 6P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to July 29 1944, and that I last saw h[illegible] alive on July 29 1944.

	Duration
Immediate cause of death Cerebral Hemorrhage	24 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles F. Hardesty M. D.
Address 34 Hardesty Av Date signed 7/29

G19490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22 B

G19490 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27d.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 E. Jefferson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rozelia TURNER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1914

8. AGE: Years 30 | Months 3 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Louisiana (Town, county, and state)
10. Usual Occupation NONE.
11. Industry or business

FATHER
12. Name Thomas Hudson
13. Birthplace Louisiana

MOTHER
14. Maiden Name Catherine Wilton
15. Birthplace Louisiana

16 (a) Informant Hospital Records.
(b) Address Johns Hopkins Hospital

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 1 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1944 at 2:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to July 29 1944 and that I last saw her alive on July 24 1944

Immediate cause of death: Disseminated Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip P. Stoltz, Jr. M. D.
Address Johns Hopkins Hospital Date signed 7-30-44

AUG 1 1944 MEDICAL SECTION

VS 8

2053

G19491
T.O.P.- 40956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19491
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs. 8 mos. 27 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street 1812 Etting Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
EDMUND GALES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1878

8. AGE: Years 65 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Washington Gales
13. Birthplace ?

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 1 - 1944 (reg...) Washington Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1944 19[illegible], at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1944 to 7/31 1944 and that I last saw h[illegible] alive on 7/31 1944

Immediate cause of death Lobar Pneumonia — Duration 9

Due to Chronic Tuberculosis of left Thigh

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address BCH Date signed 7/31/44

G19492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A G19492

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto City
(b) Street address 1019 N Howard St
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
Street No. 1019 Howard St (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Manda Barnes

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) ✓ 1876

8. AGE: Years 68 | Months ✓ | Days ✓ | If less than one day hr. ✓ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Housework

FATHER
12. Name James Lyric
13. Birthplace Md

MOTHER
14. Maiden Name Mary Howard
15. Birthplace Md

16 (a) Informant Viola Wayne
(b) Address 1019 Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 40 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Isaac D Brown Son & Hecht
(b) Address 10 N Monty omery St

19 (a) Registered by (Signature) Huntington Williams

AUG 1 1940

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1940, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1940 to July 25 1940
and that I last saw h alive on July 25 1940

Immediate cause of death: Cerebral Hemmhage — Duration: 3 days
Due to: ✓
Due to: ✓
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation: ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature James C Cupus M. D.
Address 1016 E. Heath St Date signed 8-1-40

G19493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G19493 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 E. Monument
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E Monument St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Mary Hill

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business .....

FATHER 12. Name John Still

13. Birthplace U. S. A.

MOTHER 14. Maiden Name Susan Edwards

15. Birthplace U. S. A.

16 (a) Informant Mrs Alonta Greer

(b) Address 1631 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Balto County Md

18 (a) Funeral director William A Jackson

(b) Address 844 Penna ave

AUG 1-1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to July 30 1944 and that I last saw h[illegible] alive on July 29 1944.

Immediate cause of death Mitral Insufficency

Duration

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Edward Fisher M. D.

Address 2 E Monument Date signed July 31 1944

G19494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G19494 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. Washington (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SISTER Mary Rose Malley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 20, 1863

8. AGE: Years	Months	Days	If less than one day
80	11	12	2 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name John Malley
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Malley
15. Birthplace Ireland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. St. Agnes
Location Mt. Washington

18 (a) Funeral director H. W. Mears Mfg Dom
(b) Address 805 N. Calvert St.

19 (a) AUG 1 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to August 1 1944, and that I last saw her alive on July 31 1944.

Immediate cause of death	Duration
Cardio - Resp. Failure	
Due to Hypertensive - Arteriosclerotic Cardio - Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. E. Dornbusch M. D.
Address Mercy Hospital Date signed 8/1/44

G19495

BALTIMORE CITY HEALTH DEPARTMENT 13B

CERTIFICATE OF DEATH

Registered No. 2698

G19495

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Whatcoat St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Whatcoat St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margret Kent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	married

6 (b) Name of husband or wife Isaac Kent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1904

8. AGE: Years	Months	Days	If less than one day
40	2	1	hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Day Worker

FATHER
12. Name Ben. Coates
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Jeem Thomas
15. Birthplace Calvert Co. Md

16 (a) Informant Vincent Coates
(b) Address Calvert Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-44 (month) (day) (year)
(c) Cemetery or crematory Patapsco Chapel
Location Calvert Co

18 (a) Funeral director P. L. Lowell
(b) Address Prince Frederick Md

AUG 1 - 1944 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31-1944, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24-1944, to 7-31-1944, and that I last saw her alive on 7-30-1944.

Immediate cause of death Myocarditis — Duration: uncertain

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 8-1-44

G19496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

G19496
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Redwood & Green St. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Harrington

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67	66		hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Steam Fitter
11. Industry or business

FATHER 12. Name Patrick Harrington
13. Birthplace Maryland

MOTHER 14. Maiden Name Bridget
15. Birthplace Maryland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Geo. W. Tinley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 1 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 1944, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944 to 7-31 1944, and that I last saw her alive on 7-31 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to A Nemia	
Due to Carcinoma of stomach	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-28
Major findings of operation: Carcinoma of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Lange M. D.
Address Univ. Hosp Date signed 7-31-44

G19497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119A

Registered No. G19497

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Fayette & Paca 88
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosemary Preissler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a). Single, married, widowed, or divorced. Sngl

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1943

8. AGE: Years 1 | Months | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Geo. J. Preissler
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Helen S. Black
15. Birthplace N. C.

16 (a) Informant Mr. Geo. J. Preissler
(b) Address 1926 Christian St

17 (a) Burial (b) Date thereof 8-2-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood

18 (a) Funeral director H. F. Wirth
(b) Address 4101 Edmondson Ave

19 (a) AUG 1 - 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1944 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19; and that I last saw h alive on D.O.A. 19.

Immediate cause of death	Duration
Dehydration	
Due to Infections Diarrhea	2 wks.
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Symmonds Royer M. D.
Address Bon Secours Hosp Date signed

H. Wallenwein MD Birthd Com 7/30/44

G19498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19498
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2034 Kennedy Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 Kennedy ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME nadine Wahle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Albert C. Wahle
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan 5-1873

8. AGE: Years	Months	Days	If less than one day
71	7	26	25 hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Francois H Prevost
13. Birthplace France

MOTHER
14. Maiden Name Constance Sebrun
15. Birthplace France

16 (a) Informant Mrs Frederick C Rupp
(b) Address 2034 Kennedy ave

17 (a) Burial (b) Date thereof Aug 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address 1300 Mc Culloh St

19 (a) AUG 1 1944 (b) Washington Boulevard, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to July 30 1944 and that I last saw h[illegible] alive on July 30 1944

Immediate cause of death	Duration
Cerebral hemorrhage	24 hrs.
Due to Arteriosclerosis	? years.
Klabeter, mellitus	? years.
Due to	
Other Conditions General senile changes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robt. H. Wright
Address Medical Arts Bldg. Date signed 8/1/44 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832a

G19499

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 N Milton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Mc=Dermott Deal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John J. Deal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 - 1881

8. AGE: Years 63 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name John J Cain
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Mc Carty
15. Birthplace

16 (a) Informant Joseph V Cain
(b) Address 2641 Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3-43 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Old Frederick Rd.

18 (a) Funeral director John C Horan
(b) Address 3042 E Baltimore St
Washington Funeral Home Inc

(c) (b)

AUG 1 - 1944
(Date) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1944, to July 30, 1944, and that I last saw her alive on July 30, 1944.

Immediate cause of death Cerebral hemorrhage — Duration 10 days

Due to Cerebral Sclerosis — 2

Due to — 3

Other Conditions — 4

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cassard M. D.
Address 514 Druid Park Lake Date signed 7/31/44

BOR G19500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19500 Registered No. 121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Casky (Nee) Nitkowski

3 (b) If veteran, name war: World 1
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Dora Casky
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 11-4-96

8. AGE: Years 47 | Months 8 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name SIMON CASKY
13. Birthplace Poland

MOTHER
14. Maiden Name JENNIE JEARCK
15. Birthplace Poland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) July (day) 4 (year) 44
(c) Cemetery or crematory Loudon Park
Location Wyndale Road.

18 (a) Funeral director John J. McGan
(b) Address 3010 E. Baltimore St.

19 (a) AUG 1 - 1944 (Date rec'd by registrar) (b) ... (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944, at 3:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to — 19..., and that I last saw h... alive on July 31 1944

Immediate cause of death: ? Coronary occlusion — Duration

Due to

Due to

Other Conditions: Acute appendicitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None done

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry Saunders

Address Johns Hopkins Hosp. Date signed 7/31/44

G19501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 172

G19501
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, ~~Maryland~~
(b) Street address Baltimore, Maryland
(c) ~~Hospital or institution:~~ Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 W. Saratoga Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Workman Toney

3 (b) If veteran, name war

3 (c) Social Security Account No. 250-16-4911

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Genevieve

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1916

8. AGE: Years 28 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace Mayville, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Lou Toney

13. Birthplace S.C.

MOTHER 14. Maiden Name Hattie Fortune

15. Birthplace S.C.

16 (a) Informant Genevieve Toney

(b) Address 1612 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)

(c) Cemetery or crematory Sumter

Location South Carolina

18 (a) Funeral director A. Halstead

(b) Address 718 Druid Hill Ave.

19 (a) (b) Registrar

AUG 1 1944

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944, at 4:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed fracture of skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-1-44 at 2:45 A.M.
(b) Where did injury occur? Pier # 7 foot of Clinton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes.
(d) Means of injury Fell in hold of ship.

23. Signature Robert Lee Gutman M.D.
Medical Examiner.
Date signed August 1, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19502 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Schaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth L. Schaum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1899

8. AGE: Years 45 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Beth. Fairfield

FATHER
12. Name William Schaum
13. Birthplace Germany

MOTHER
14. Maiden Name ~~Katterin~~ ANNA
15. Birthplace Germany

16 (a) Informant Mrs Annie Schaum
(b) Address 3577 Seventh St, Brooklyn, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Md.

18 (a) Funeral director William M Marsek
(b) Address 715 Light St

19 (a) (Filed by registrar) AUG 1 1944 (b) Huntington White Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1944, at 10:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, Lobar.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNeill, M.D. Medical Examiner.
Date signed 7/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G19503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19503 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/28/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/28/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rivera Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEROY SYLVESTER ZITTLE SR

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	218-22-0866	Male	White	Married

6 (b) Name of husband or wife Alice A. Strami
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 3, 1883

8. AGE: Years	Months	Days	If less than one day
61	0	17	hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)
10. Usual Occupation Painter (Civilian)
11. Industry or business USCG Yard, Curtis Bay, Md.

FATHER
12. Name James Zittle
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Bechtel
15. Birthplace Maryland

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md
18 (a) Funeral director William M Marech
(b) Address 745 Light St Washington Williams, Md.
19 (a) AUG 1 - 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH July 30, 1944, at 3:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1944, to July 30, 1944, and that I last saw him alive on July 30, 1944

Immediate cause of death 1. Myocardial infarction; 2. Hypostatic pneumonia — Duration Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. K. Aldrich M. D.
Address Baltimore, Md. Date signed 7/31/44

VS 150

ECC-54491

G19504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G19504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 W. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 W. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Sibley

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-26-1212

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-18

8. AGE: Years 25 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Cheraw, S.C. (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER 12. Name Phillip Broadie
13. Birthplace S.C.

MOTHER 14. Maiden Name Jennetta Grady
15. Birthplace S.C.

16 (a) Informant Estell Archer
(b) Address 1401 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-44 (month) (day) (year)
(c) Cemetery or crematory
Location Cheraw, S.C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 (a) AUG 1 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31- 1944 at 4 20/24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-1944 to 7-31-1944, and that I last saw h-r alive on 7-31-1944.

Immediate cause of death — Duration
Cardiac Decompensation
Due to Hypertension — 9 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lorus M. Warren M. D.
Address 2340 Madison Ave Date signed 8-1-44

G19505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19505
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd - Calvert St
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Oakmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 - 10th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Roberson Pogue

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Elizabeth Pogue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1893

8. AGE: Years	Months	Days	If less than one day
50	7	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Industrial Engineer
11. Industry or business

FATHER
12. Name William M. Pogue
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Gertrude Roberson
15. Birthplace Maryland

16 (a) Informant Mrs. William R. Pogue (Elizabeth)
(b) Address 815 10th St. Oakmont, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4 1944 (mo.) (day) (year)
(c) Cemetery or crematory Brookview
Location Pasadena Md.

18 (a) Funeral director J. C. Tyson
(b) Address Pasadena Md.

19 AUG 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1944 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944 to Aug 1 1944
and that I last saw him alive on Aug 1 1944

	Duration
Immediate cause of death: Heart failure	7 days
Due to Pulmonary congestion	7 days
Due to Beamorrocus fever - Nausea	7 days
Other Conditions Coronary heart disease	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward P. Grove
Address Union Memorial Hosp. Date signed Aug 1 1944 M. D.

G19506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered G19506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 644 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel F. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 73 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER 12. Name: Samuel F. Williams

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden Name: Clara Magee

MOTHER 15. Birthplace: Md

16 (a) Informant: Anita Williams

(b) Address: 644 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 3/44 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral Cem

Location: Fredrick Road

18 (a) Funeral director: Mrs. Robert O. Elliott & Son

(b) Address: 1129 N. Carrollis St Huntington Williams, Md

19 (a) AUG 1 - 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1944, to July 31 1944, and that I last saw h alive on July 30 1944

Immediate cause of death: Cirrhosis of liver — Duration: months

Due to:

Due to:

Other Conditions: Cardio - Renal disease — Duration: months

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Bernard Harris M. D.

Address: 1207 a Cordell St Date signed: Aug 1, 1944

G19507 ~~45-400~~

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 12a

Registered No. G19507

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glyndon (If outside city or town limits, write RURAL and give town)
(d) Street No. Circuit Heart Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-29-44

8. AGE: Years | Months: 1 | Days: 2 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Melvin Williams.
13. Birthplace Md.

MOTHER 14. Maiden Name Onvetta Wimpell
15. Birthplace N. Ca.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3/44 (month) (day) (year)
(c) Cemetery or crematory Piney Grove
Location Balto Co.

18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown Md.

AUG 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1944 at 4.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1944 to Aug - 1 1944, and that I last saw h. on alive on August - 1 1944.

Immediate cause of death: Renal failure — Duration: 24 hrs
Due to: Idiopathic thrombo-cytopenic purpura — 5 wks
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: hemorrhages in lungs & kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Kaye M. D.
Address Johns Hopkins Hosp. Date signed 8-1-44

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1700

G19508 Registered No.

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth L. McWhirter

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944; at 3:35 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John J. McWhirter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1867

8. AGE: Years	Months	Days	If less than one day
About 77	2	29	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James B. Lynch
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Murray
15. Birthplace Virginia

16 (a) Informant Miss Helen C. McWhirter
(b) Address 714 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

AUG 2 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hematoma, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 12/1 45

(a) Date of injury July 31 1944 6 P.M.
(b) Where did injury occur? St. Paul St. & Stratford Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Collision 2 autos

23. Signature Robert Lee Gretz M.D. Medical Examiner.
Date signed August 1, 1944.

VS 151

G19509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131

G19509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Mt. Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Sauter

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-1170

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Lenora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1878

8. AGE: Years	Months	Days	If less than one day
65	11	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Expiditor

11. Industry or business Maryland Dry Dock

FATHER 12. Name Joseph Sauter

13. Birthplace France

MOTHER 14. Maiden Name Elizabeth Junker

15. Birthplace ?

16 (a) Informant Mrs Marie E. Anton

(b) Address 802 Mt. Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3, 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Brooklyn

18 (a) Funeral director Leonard J. Kuck

(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b)

AUG 2 - 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31st 1944, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1944, to July 31, 1944, and that I last saw him alive on Aug 1st 1944.

Immediate cause of death Ch. Valvular Heart Disease — Duration 2 yrs.

Due to

Due to

Other Conditions Ch. Nephritis — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo E. Wells M. D.

Address 4100 Edmondson Ave Date signed 8-1-44

G19510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 46a

G19510
Registered No.

PRINTED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1846 Lorman
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorenzo Vessels

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-8529

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10-1898

8. AGE: Years 46 | Months 8 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Bell hop

11. Industry or business

FATHER
12. Name Beregard Vessels
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie Keys
15. Birthplace Virginia

16 (a) Informant Carrie Vessels (mother)
(b) Address 1815 Kavanaugh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 AUG 2 - 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jul 30 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1942, to Jul 30 1944
and that I last saw him alive on Jul 25 1944

Immediate cause of death: Removal of growth on Esophagus — Duration

Due to

Due to Carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hal D Woolridge M. D.

Address 7031 W Pratt Date signed 8-1-44

G19511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119W

Registered No.

G19511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Fairhaven ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) 4-30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Fairhaven ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Lee Allen

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 44

8. AGE: Years | Months 4+30 | Days 19 | If less than one day hr. — min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Thomas Roy Allen
13. Birthplace Georgia

MOTHER 14. Maiden Name Minnie Matthews
15. Birthplace Georgia

16 (a) Informant Mr Thomas Roy Allen
(b) Address 3906 Fairhaven Ave

17 (a) Burial (b) Date thereof Aug 3-44 (month) (day) (year)
(c) Cemetery or [redacted] Cedar Hill
Location Ritchie Highway, Md.

18 (a) Funeral director Mitton & Sheilds
(b) Address 3944 Hanover St Huntington Williams, Md.

AUG 2 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2nd 1944 at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Aug 2 1944 and that I last saw him alive on Aug 2 1944.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Enteritis — 2 Weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 47 Penrose Ave Date signed 8/2/44

G19512

G19512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Third St
(c) Hospital or institution: Balto 25-Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Third St (Brooklyn) 25
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millard S. Leister

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-3525 World

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Marie J. Leister
6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.) October 28-1862

8. AGE: Years 81 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Harpers Ferry Md
(Town, county, and state)

10. Usual Occupation Locomotive Engineer

11. Industry or business B&O R R

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Louis Marconi
(b) Address 3711 Third St Brooklyn

17 (a) Burial (b) Date thereof Aug 4-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Marys (Hampden)
Location Balto. Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

AUG 2-1944 Huntington Williams Reg MD
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1944, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Aug 1 1944 and that I last saw alive on July 31 1944

Immediate cause of death	Duration
Acute Dilatation of Heart	1 da.
Due to Mitral Regurgitation	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell
Address 1644 Hanover St Date signed 8/3/44

G19513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12-A Registered No. G19513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Ridgely St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** IRVING M. WENZEL

3 (b) If veteran, name war: no

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frieda

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June 30. 1892

8. AGE: Years 52 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Interior Decorator

11. Industry or business

FATHER 12. Name Ernest A. Wenzel

13. Birthplace Balto Md

MOTHER 14. Maiden Name Katie C. Schuchner

15. Birthplace Balto Md.

16 (a) Informant Ernest A. Wenzel

(b) Address 4510 Poplar Ave. Hatelhope

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3. 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore City

Location

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son

(b) Address 801 W. Fayette St. Baltimore, Md.

AUG 2 - 1944 (Date rec'd by Registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 1 1944 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1944, to 8-1 1944, and that I last saw him alive on 8-1 1944

Immediate cause of death Respiratory Failure — Duration .....

Due to Coronary Occlusion — .....

Due to Myocarditis — .....

Other Conditions — .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy Coronary Occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Leon J. Greenbaum M.D.

Address Sinai Hosp. Date signed 8-1-44

G19514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Draper Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. Boston

3 (b) If veteran, name war None

3 (c) Social Security Account No. 717-07-8901

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence E.

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 16, 1874

8. AGE: Years 70 Months 3 Days 15 If less than one day hr. min.

9. Birthplace Covington Va (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business. Penn R R.

FATHER
12. Name Solomon L Boston
13. Birthplace Va

MOTHER
14. Maiden Name Mary E Britton
15. Birthplace N J

16 (a) Informant Florence E Boston
(b) Address 5212 Draper Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (months) (day) (year)
(c) Cemetery or crematory Baptist
Location Roanoke County Va

18 (a) Funeral director Lawson & Lawson
(b) Address Campbell Ave

19 AUG 2 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1944, at 10:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed August 1, 1944.

VS 151

G19515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19515 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2649 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2649 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Pearson

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1889

8. AGE: Years 55 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace -
(Town, county, and state)

10. Usual Occupation Social Nurse - retired

11. Industry or business University Maryland

FATHER
12. Name Charles H. Pearson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Carrie Caldwell
15. Birthplace unknown

16 (a) Informant Mr. Pearson Sunderland
(b) Address 3413 Ellamont Rd. -15

17 (a) Burial (b) Date thereof 8/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) AUG 2 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944, at 4 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentress M.D.
Medical Examiner.
August 1, 1944

G19516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

Registered No. G19516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2728 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2728 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Mary Elizabeth Eliason

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1855

8. AGE: Years	Months	Days	If less than one day
88	9	26	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Naudain
13. Birthplace Del.

MOTHER
14. Maiden Name Elizabeth --
15. Birthplace --

16 (a) Informant Mr. Henry C. Eliason
(b) Address 2728 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1933, to July 31 1944 and that I last saw h-- alive on 19

Immediate cause of death	Duration
Cardiac Hypertension	2 days
Due to Myocarditis	4 yrs
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Herbert M. Foster, M.D.
Address 2724 St. Paul St. Date signed July 31-44

G19517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1090

G19517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Clifton Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Edward M. Kaufman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1881

8. AGE: Years	Months	Days	If less than one day
63	3	2	hr. min.

9. Birthplace W. Va. (Martinsburg)
(Town, county and state)

10. Usual Occupation Boiler Maker

11. Industry or business B & O. R.R.

FATHER
12. Name John W. Kaufman
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Marion V. Oden
15. Birthplace Md.

16 (a) Informant Daisy Kaufman
(b) Address 3813 Clifton Ave. Balto.

17 (a) Burial (b) Date thereof 8/4/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tiffeney & Sons
(b) Address Balto., Md.

19 (a) AUG 2 1944 (b)
(Registrar's signature)
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 1944, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1944 to 7/31 1944, and that I last saw h[illegible] alive on 7/31 1944.

Immediate cause of death Atypical pneumonia — Duration

Due to Congestive Heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl Myers

Address Mt. Sinai Hosp. Date signed 7/31/44
M.D.

G19518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G19518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 N. Charles St.
(c) Hospital or institution:
Notre Dame of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 N. Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Victoria - Theresa Statto

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-1865

8. AGE: Years	Months	Days	If less than one day
79	4	17	hr. min.

9. Birthplace Rochester N.Y.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Statto
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Gisk Statto
15. Birthplace Germany

16 (a) Informant Loretta Statto
(b) Address 550 Lyell Ave Rochester N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-44 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Homeland Ave

18 (a) Funeral director George Funk & Son
(b) Address 811 N. W. olfe St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 2 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2nd 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to Aug 1 1944 and that I last saw h alive on Aug 1 1944

Immediate cause of death	Duration
Myocarditis & Decompensation	
Due to Sclerosis & Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Francis L. Bagli M. D.
Address 6077 Hanford Rd Date signed

G19519

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 196

G19519
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give locality)
(d) Street No. 3522 O'Donnell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No).
If yes, name country

3 (a) FULL NAME Frank Lamke

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-5126

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband~~ wife Sophie Lamke

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) ? 1889

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Galvanizer
11. Industry or business Anchor Post Fence Co.

FATHER
12. Name Stephen Lamke
13. Birthplace Poland

MOTHER
14. Maiden Name Dora Olszewski
15. Birthplace Poland

16 (a) Informant Sophie Lamke (wife)
(b) Address 116 So. Durham St.

17 (a) Burial (b) Date thereof 8-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore, Co., Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Caroline St
Huntington Williams Undertaker

AUG 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944, at 11:14 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage, spontaneous

Due to Ruptured aneurysm of middle cerebral artery

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fretz M.D.
Medical Examiner.
Date signed August 1, 1944.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19520 T.G.P.-88711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176 D

G19520 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo, 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 East Lombard Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Firnstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Phillip
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1881

8. AGE: Years 63 | Months 5 | Days 21 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Blessing (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie ?
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Lyons Sons
(b) Address Roland Ave & Belair Rd

19 (a) (Signature and title) (b) Huntington Williams, M.D. Registrar

AUG 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1944 to 7/30 1944, and that I last saw h[illegible] alive on 7/30 1944.

Immediate cause of death: generalized Peritonitis — Duration 10 days
Due to: Parenteritis — 10 days
Due to: — over
Other Conditions: Agnogenic Myeloid Metaplasia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same - Subjutto Mmmmmm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Shea Halle M. D.
Address BCH Date signed 7/31/44

G19521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19521 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/28/1895

8. AGE: Years 49 Months - Days 3 If less than one day hr. min.

9. Birthplace South Carolina (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Cezar Wilson
13. Birthplace South Carolina

MOTHER
14. Maiden Name Rena
15. Birthplace South Carolina

16 (a) Informant Jerimia Wilson
(b) Address 1620 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

AUG 2 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. W. Clemmler M.D. Medical Examiner.
Date signed August 2, 1944.

VS 151

G19522

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

153

G19522

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ weeks

Hospital, institution, or street address where death occurred:

1701 Ellamont St

How long in hospital or institution? 2½ weeks

15 16

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County .....

City or town Balto (If outside city or town limits, write RURAL and give nearest town)

Street No. 1701 Ellamont Ave. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Mrs. Esther Becker

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name Joseph Berger

13. Birthplace Russia

MOTHER 14. Maiden name Unknown

15. Birthplace .....

16. Informant .....

Address .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 3 44 (month) (day) (year)

Cemetery or crematory Chev Sholem Cemetery

Location Washington D C.

18. Funeral director B. Danzansky

Address 3501-14th St NW Washington, DC

AUG 2 1944 (Date received by Registrar) 19 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2nd 19 44 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 17 19 44, to August 2 19 44 and that I last saw h ER alive on August 1 19 44

Immediate cause of death Pneophigus

DURATION: 9 months

Due to .....

Due to .....

Other conditions Uremia

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....

Autopsy results None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frederic A. Klein, M.D. M. D. or other

Address 833 Park Ave Date signed 8-2-44

In especially important cases, physicians please write in full. Statistics of this county are legally

G19523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Freeman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie V. Sylvia

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Wm. T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1880

8. AGE: Years	Months	Days	If less than one day
64	4	24	hr. min.

9. Birthplace Virgina (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Geo. W. Elliott
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah E. Elliott
15. Birthplace Va.

16 (a) Informant Mrs. Maude V. Hall
(b) Address 3112 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory Tappahannock
Location Tappahannock Va.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

(a) Date received AUG 2 1944 (Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1944 to July 30 1944, and that I last saw h alive on July 30 1944

Immediate cause of death	Duration
central hemorrhage	
"apoplexy"	
Due to hypertension CV disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary N. Kenton MD
Address 202 Patapsco Av Date signed 7/31/44 D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

19524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19524 Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) not known.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4430 Wickford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M Damman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1849

8. AGE: Years 94 Months 8 Days 7 If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Dorman
13. Birthplace Scotland

MOTHER 14. Maiden Name Ann M Bromley
15. Birthplace Va

16. (a) Informant A. Rudolph Stewart
(b) Address 4430 Wickford Road

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug 2-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director John Mitchell Sons
(b) Address 1420 Eutaw Place

AUG 2 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1944, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944, to Aug 1 1944, and that I last saw her alive on Aug 1 1944

Immediate cause of death: Cerebral Vascular Accident — Duration: 3 months.

Due to Hypertensive Cardio Vascular Disease — Duration: many years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M. D.
Address 12 E. Eager St. Date signed Aug 1, 44

G19525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G19525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Highland Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Highland Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN M. WIENECKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lydia Wienecke

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1892

8. AGE: Years 51 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Dealer (auto.)

11. Industry or business Sell

FATHER 12. Name Edward H. Wienecke

13. Birthplace Balto, Md.

MOTHER 14. Maiden Name Mollie Link

15. Birthplace Balto. Md

16 (a) Informant Mrs. Edw. H. Wienecke (wife)

(b) Address 211 S Highland Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)

(c) Cemetery or crematory Oaklawn

Location Eastern Av.

18 (a) Funeral director Lilly & Geiter & Sons

(b) Address 403 N Wolfe St

(a) AUG 2 - 1944 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1944 at 1 30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.

Date signed 8-3-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARC... RESERVED FOR RECORDING

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

G19526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19526

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Gilbert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Carney (If outside city or town limits, write RURAL and give town)
(d) Street No. Summit Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mildred M Liersemann (Liersemann)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Julius Conrad Liersemann

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/5/1907

8. AGE: Years 36 | Months 7 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore City, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name John Jenkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Ann Keiningham
15. Birthplace Virginia

16 (a) Informant Husband
(b) Address Summit Ave., Carney, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4 (month) (day) 44 (year)
(c) Cemetery or crematory Pikesville
Location .....

18 (a) Funeral director Leonard V. Rueck
(b) Address 305 Harford Rd.

19 (a) (Date received by registrar) AUG 2 - 1944 (b) Huntington Williams, M.D. Address .....

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 1944, at 10 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1944 to Aug 1 1944, and that I last saw her alive on Aug 1 1944.

Immediate cause of death: Pulmonary edema — Duration: 3 hrs.

Due to: Heart failure — Duration: 4 hrs.

Due to: Agranulocytic angina — Duration: .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Glenn P. Spurr M. D.
Address Union Memorial Hosp. Date signed 8/1/44

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G19527

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Pinewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Pinewood Ave (if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otelia L. O'Connor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Patrick M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1863

8. AGE: Years	Months	Days	If less than one day
80	7	27	hr. min.

9. Birthplace St. Mary's Co. Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Raley
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Weinberg
(b) Address 2910 Pinewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date received by Registrar) AUG 2 1944 (b) Washington Millinery, Inc. (Signature)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1936, to Aug 1 1944 and that I last saw h. alive on Aug 1 1944

Immediate cause of death	Duration
Acute Pulmonary edema	1 wk
arteriosclerotic cardio vascular renal disease	20 yrs.
Due to Carcinoma of nose	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Alessi

Address 6217 Harford Rd Date signed 8/7/44

G19528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19528 Registered No. 944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 367 Evesham Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 367 Evesham Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK KOTWALL (Kotwald)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Irene Ptasinsky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/8/69

8. AGE: Years 75 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Mrs. B. Malach (daughter)
(b) Address 367 Evesham avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
Cemetery or crematory Oak Hill
Location Baltimore Md

18 (a) Funeral director Chas. B. Schimmel
(b) Address 2601-03 E. Monument

19 (a) Date received by registrar AUG 2 - 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944 at 6 A M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. L. Wallenmeyer M.D. Medical Examiner.
Date signed 7-31-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

G19529 BALTIMORE CITY HEALTH DEPARTMENT G19529
Registered No.

CERTIFICATE OF DEATH 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Ramsay St.
(c) Hospital or institution: 2013
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Ramsay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Muspelhorn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/28/1897

8. AGE: Years	Months	Days	If less than one day
46	7	3	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Albert E. Muspelhorn
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Mc Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Emma Mc Muspelhorn
(b) Address 2011 Ramsay St

17 (a) Burial (b) Date thereof Aug 7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. D. Heppeat Sons
(b) Address Baltimore, Fremont St.

19 (a) AUG 2 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31st, 1944, at 3:15 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29, 1944 to July 31, 1944, and that I last saw h[illegible] alive on July 31, 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Friedman, M.D.
Address 1319 Eutaw St Date signed 8/1/44

a36713
G19530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 159

G19530
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent Co.
(c) City or town Worton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Reynolds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-4

8. AGE: Years | Months | Days: 13 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Herman Reynolds
13. Birthplace Va.

MOTHER
14. Maiden Name Martha ?
15. Birthplace Minn.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory Church
Location Chestertown Md.

18 (a) Funeral director Maggie L. Willing
(b) Address Chestertown Md.
(Date rec'd by registrar) AUG 2 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1944 at 8 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to Aug 2 1944 and that I last saw her alive on Aug 2 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to acidosis	5 days
Due to acute nutritional disturbance (diarrhea)	5 days
Other Conditions prematurity	11 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp. Date signed 8-2-44

JL67741 G19531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19531 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 4940 Eastern Ave.

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 11 -25

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1141 Monroe Circle (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Junius Johnson

3 (b) If veteran, name war.

3 (c) Social Security Account No. 218-09-6158

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife [redacted] Tracie Johnson (nee Dawson) 6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1918

8. AGE: Years	Months	Days	If less than one day
26	3	1	hr. min.

9. Birthplace N. C., Chatham County (Town, county, and state)

10. Usual Occupation Pipe Fitter's Helper

11. Industry or business Edgewood Arsenal

FATHER — 12. Name June Johnson

FATHER — 13. Birthplace N. C.

MOTHER — 14. Maiden Name Janie Ann Watson

MOTHER — 15. Birthplace Ga.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 1944 (month) (day) (year)

(c) Cemetery or crematory Mary Lincoln Bern

Location a. a. 2

18 (a) Funeral director C. Bufford Evans

(b) Address 1400 E. Baltimore St.

19 (a) (Date received by registrar) AUG 2 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 - 31 1944, at 945 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1941, to 7-31 1944.

I last saw him alive on 7-31 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions Myocardial disease, etio. unknown (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Edwards, Jr. M. D.

Address City Hosp. Date signed 8-1

G19532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

G19532 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Gist St.
(c) Hospital or institution Provident Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Marshall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Lippermann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1943

8. AGE: Years 8 Months 8 mo. Days 29 If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Same
13. Birthplace Balto.

MOTHER
14. Maiden Name Mildred Rheupt
15. Birthplace Balto.

16 (a) Informant Family
(b) Address 1603 Marshall St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-4-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson
18 (a) Funeral director James L. McCauley
(b) AUG 3 1944 Date rec'd by registrar Registrar

19 (a) (Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2-1 1944 at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2-1944 to 8-2-1944, and that I last saw her alive on 8-2-1944.

Immediate cause of death Acute tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Lippmann M.D.
M. D.
Address Balto. Gen. Hosp. Date signed 8-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4305 Marble Hall Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Marble Hall Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. McSweeney

3 (b) If veteran, name war

3 (c) Social Security Account No. ---------

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William McSweeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Herlihy
15. Birthplace Ireland

16 (a) Informant Mr. Jos. M. McSweeney
(b) Address 3404 Caton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 Park Ave.

AUG 3 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1944 at 7:30 A

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944 to Aug 1 1944 and that I last saw her alive on Aug 1 1944

Immediate cause of death: Angina Pectoris — Duration 2 days

Due to: Arteriosclerosis — Duration 2 yrs

Due to: — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward D. [illegible] M. D.
Address 7020 N. Charles Date signed 8/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

19534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Just Came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Welch

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-01-3976

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Flora Welch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1881

8. AGE: Years	Months	Days	If less than one day
63	2	8	hr. min.

9. Birthplace Mary Land (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nannino Welch
13. Birthplace Ireland

MOTHER
14. Maiden Name E. Elkins
15. Birthplace W. Va.

16 (a) Informant Mrs. Flora Welch
(b) Address Keys Funeral Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5-1944 (month) (day) (year)
(c) Cemetery or crematory Oak Cemetery
Location Oakley Hill Frederick

18 (a) Funeral director D. B. Hartsell Sons
(b) Address Keys Funeral Home Burial

19 AUG 3 1944 Hampstead Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1944, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23 1944, to 8/2 1944, and that I last saw him alive on 8/2 1944.

Immediate cause of death	Duration
Resp. Failure	
Due to Pneumonia terminal	
Due to Profound Anemia	
Other Conditions Chronic Lymphoid Leukemia	Chronic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. M. P. Crosby
Address Mercy Hosp. Date signed 8/3/44

G19533 BALTIMORE CITY HEALTH DEPARTMENT ✓ G19535
CERTIFICATE OF DEATH 94W Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians:- please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Hamilton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy E Wolfe (WOLFE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/1879

8. AGE: Years 65 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Issac Wolfe
13. Birthplace

MOTHER
14. Maiden Name Emma Floyd
15. Birthplace Md.?

16 (a) Informant Baltimore City Hospital
(b) Address

17 (a) Burial (b) Date thereof 8/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd., Balto., Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received by Registrar) AUG 3 1944 (b) Registered No. [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1944, at 12:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallammeier M.D.
Medical Examiner.
Date signed August 4 1944.

G19536 BALTIMORE CITY HEALTH DEPARTMENT G19536

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Denison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth WILSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1851

8. AGE: Years	Months	Days	If less than one day
93	5	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Seback
13. Birthplace Alsace Lorraine

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Emma W. Smith
(b) Address Short Hills, N. J. - Box 146

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar

AUG 3 1944
VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1 1944 at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1944 to 8/1 1944 and that I last saw h alive on 7/31 1944

Immediate cause of death	Duration
Cerebral accident	2 wks.
Due to Arteriosclerosis	?
Due to Pulmonary edema	10 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert G. Reese M. D.
Address 3408 Windsor Av. Date signed 8/1/44

G19537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19537 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 W. 37th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 W. 37th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE MAY COVER

3 (b) If veteran, name war: **

3 (c) Social Security Account No.: **

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: Alonzo J. Cover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1877

8. AGE: Years 67 | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace: Frederick, Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Addison R. Ruse
13. Birthplace: --

MOTHER
14. Maiden Name: Alice Kussmaul
15. Birthplace: Frederick

16 (a) Informant: Mr. Harry R. Ruse
(b) Address: 402 Somerset Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Frederick, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received: AUG 3 1944 (b) Registrar: Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1943 to July 31 1944 and that I last saw her alive on July 31 1944.

Immediate cause of death: Chronic Myocarditis -
Due to: Coronary Thrombosis
Due to: Generalized arteriosclerosis & Coronary Sclerosis

Duration: Indefinite / 6 wks / Indefinite

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: Nathaniel M Beck M. D.
Address 2727 N. Charles St Date signed Aug 1 44

G19538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL (MIKE) D. KAKAROUKAS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Helen M Kakaroukas

6 (c) If divorced, how long? years

7. Birth date of deceased (mo., day, yr.) Oct 5 1899 Jan 7 1899

8. AGE: Years 44 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER 12. Name James Kakaroukas
13. Birthplace Greece

MOTHER 14. Maiden Name Julia Tsakas
15. Birthplace Greece

16 (a) Informant Helen Kakaroukas
(b) Address 520 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-44 (month) (day) (year)

(c) Cemetery or crematory
Location Monnesson Pa

18 (a) Funeral director Sambros Funeral Home Inc
(b) Address 440 E. North Ave

19 (a) AUG 3 1944 (Date received by Registrar) Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2, 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D. Asst Medical Examiner.

Date signed 8-3-44

19539 Blacks 2139 R.H.M. BALTIMORE CITY HEALTH DEPARTMENT V G19539

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Fairfield Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, state R.F.D. No., or private town)
(d) Street No. 3316 Fairfield Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 180 | Months | Days | If less than one day hr. min

9. Birthplace Middlesex Co Va (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Sippy Winkfield

13. Birthplace Va

MOTHER 14. Maiden Name Mildred Thomas

15. Birthplace Va

16 (a) Informant Richard Fallon

(b) Address 3316 Fairfield Rd

17 (a) Burial (b) Date thereof Aug 3-44
(Burial, cremation, or removal) (month) (year)

(c) Cemetery or crematory Fort Calvary Cemetery
Location A.A. Co. Md.

18 (a) Funeral director Robert Stull

(b) Address 1515 McCulloh St

19 (a) AUG 3 - 1944 Huntington Ave Baltimore, Md.
(Date received) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1944 at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1944 to 7/31 1944 and that I last saw h.er alive on 7/28 1944

Immediate cause of death Cerebral Hemorrhage

Due to Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

G19540 [redacted] G19540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Reuckert Ave
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Moran

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-44

8. AGE: Years | Months | Days | If less than one day hr. 5 min.

9. Birthplace Baltimore, Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James A. Moran
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs James A. Moran
(b) Address 3104 Reuckert ave, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director [redacted]
(b) Address [redacted]

19 AUG 9 1944 [redacted] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2- 1944 at 2 37 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1944 to 8-2- 1944 and that I last saw h[illegible] alive on 8-2- 1944

Immediate cause of death Resp. Failure — Duration 5 Min

Due to Hemicronium — Duration con-genital

Due to Meningocele

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8-3-44
Major findings of operations: Hemicronium Meningocele
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen J. Tunstall M. D.
Address Union Memorial Hosp. Date signed 8-3-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR BINDING

Dr Conrad S. Amberecrombie

3524 Greenmount Ave

G19541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G19541

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days) 79 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Helbner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 24-1865

8. AGE: Years 79 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Conrad Helbner
13. Birthplace Germany

MOTHER
14. Maiden Name Rosetta B. Tamert
15. Birthplace Baltimore Md.

16 (a) Informant Ella V. Hofmeister
(b) Address 1814 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) 8/3/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1944, at 10.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1920 to Aug 1 1944, and that I last saw her alive on Aug 1 1944.

Immediate cause of death Cerebro-pulmonary complications due to Diabetes Mellitus — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Claude S Abercrombie M. D.
Address 3524 Greenmount Date signed Aug 3 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

VS 150

G19542
T.C.P.-69008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3b

G19542
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. · Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Spray Ct. Gilmore Project ?
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Dora Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1913

8. AGE: Years	Months	Days	If less than one day
31	4	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Ford
13. Birthplace ?

MOTHER
14. Maiden Name Rosetta Stansburg
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4/1944 (month) (day) (year)
(c) Cemetery or crematory Light Street Baptist Cem.
Location Waverly Md

18 (a) Funeral director Mrs. Eva A. Holland
(b) Address 1629 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944 19 , at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1944, to 8-1 1944 and that I last saw him alive on 8-1 1944

Immediate cause of death pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Berry, Jr. M. D.
Address City Hosp. Date signed 8-1

~~G19543~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G19543
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days): 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2371 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

9-3

3 (a) FULL NAME: Michael Nelson

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	16	hr. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: Retired Laborer

11. Industry or business: Swift Company

FATHER
12. Name: Michael Nelson
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Campbell
15. Birthplace: Ireland

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: 4300 Old Fred. Road

18 (a) Funeral director: John F. Cowan & Son
(b) Address: 901-03 Hollins St.

19 (a) AUG 3 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1944, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1944, to 8-1-1944, and that I last saw h. alive on 8-1-44.

Immediate cause of death	Duration
Cardiac failure	
Due to: Hypertensive Cardio-vascular disease	
Due to:	
Other Conditions: Benign hypertrophy of prostate. (Include pregnancy within 3 months of death)	

Date of operation: —
Major findings of operation: —
of autopsy: Same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury: —

23. Signature: S. P. Aksara, M. D.
Address: 4940 Eastern Ave. Date signed: 8-2-44

S. P. Aksara

45-42
G19544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 D

G19544
Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4600 Maine Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Gwenolda Stevens — Edith Gwenola Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry R Stevens
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 6 1896 6-6-96

8. AGE: Years 48 | Months 1 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Thomas R. Thomas
13. Birthplace Wales, England

MOTHER
14. Maiden Name Cornelia Keyser
15. Birthplace Baltimore Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Dunmore Cemetery
Location Dunmore Borough, Pa.

18 (a) Funeral director Wilkie Lawrence
(b) Address 2400 Liberty Heights Ave.

19 AUG 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 1 1944, at 424 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1944, to Aug - 1 1944, and that I last saw h.. alive on Aug 1 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Anemia	
Due to Cause unknown	
Other Conditions Acute pericarditis	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Wm. S. Spruill M.D.
Address Johns Hopkins Hosp. Date signed 8-1-44 M D

G19545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193d

G19545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1843 Lorman Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1843 Lorman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Hayth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25 1884

8. AGE: Years 60 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Levi Hayth
13. Birthplace North Carolina

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Maude Hayth
(b) Address 1843 Lorman Street

17 (a) (Burial, cremation, or removal) (b) Date thereof 8/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore City

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Pennsylvania Ave.
(c) (Date rec'd by registrar) AUG 3 - 1944 Huntington Williams M.E. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944 at 10 P. M

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic hypertrophy Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
(Medical Examiner)
Date signed August 2 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G19546

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Frederick Ave
(c) Hospital or institution: St. Agnes Hosp. D. O. A. 28 44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT RAY MATTHAI

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 705-05-6202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Helen M. Matthai
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 11-26-1889

8. AGE: Years	Months	Days	If less than one day
54	8	6 5	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Yard Foreman
11. Industry or business B & O R. Wy

FATHER
12. Name Christian Matthai
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Speelman
15. Birthplace Balto. Md

16 (a) Informant Helen M. Matthai
(b) Address 4700 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 4-44 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Son, Inc
(b) Address North Ave. & Broadway

19 (a) (Signature of registrar) (Date received) Huntington Williams M.D.
AUG 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1944 9.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Due to Cardiac failure	
Due to Coronary Thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A W Dyer Jr M.D. M. D.
Address St Agnes Hospital (Date signed)

Reported: Robert La Fratera M.D. August 3 1944

G19547 RAFFERTY. G19547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Riverside (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME James W. Rafferty

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-01-3244

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary Rafferty
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Apprentice Iron Worker
11. Industry or business Maryland Steel Co

FATHER
12. Name Michael J. Rafferty
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Wagner
15. Birthplace Md.

16 (a) Informant Mary Rafferty
(b) Address 1133 Riverside

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1128 Light St.

AUG 3 1944 (b) Huntington, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1/44 19 at 6:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1944, to 8/1 1944, and that I last saw him alive on 8/1 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Brain tumor malignant	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/28/44

Major findings of operation: Inoperable tumor of brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clyde Randall, M.D.
Address University Hosp Date signed 8/1/44

G19548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

G19548 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 E. Oliver Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter N. VanDaniker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1938

8. AGE: Years 5 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Joseph B. VanDaniker

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Ida V. Cook

MOTHER 15. Birthplace Baltimore Md

16 (a) Informant Mrs. Joseph B. VanDaniker

(b) Address 2035 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location E. Monroe Ave

18 (a) Funeral director Elmer W. Conkle & Son

(b) Address 924 E. Eager St

19 AUG 3 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1944 at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8/1/44 at 8-7 2.55 P.M.

(b) Where did injury occur? Federal & Chester Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Pedestrian struck by automobile

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed August 2 1944

G19549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19549
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 Idaho Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Idaho Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME G. Herbert Cox

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Florence J. Cox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3rd 1872

8. AGE: Years	Months	Days	If less than one day
71	10	2928	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Service Man
11. Industry or business American Can Co.

FATHER
12. Name Gorshum Cox
13. Birthplace Maine

MOTHER
14. Maiden Name Amelia —
15. Birthplace Md

16 (a) Informant Mildred Breining
(b) Address 4114 Idaho Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 4 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lessahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received) AUG 3 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1st 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3, 1944, to Aug. 1, 1944, and that I last saw him alive on Aug. 1, 1944

Immediate cause of death	Duration
Coronary thrombosis	1 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Groth, M.D.
M. D.
Address 6100 Harford Rd. Date signed 8/4/44

G19550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G19550 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Divorced.

6 (b) Name of husband or wife Sarah Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906, June

8. AGE: Years	Months	Days	If less than one day
38	2		hr. min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant James Mann
(b) Address 561 Orchard St.

17 (a) Burial (b) Date thereof 8/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

AUG 3 - 1944

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1-44 19 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31-44 19 to 8-1-44 19, and that I last saw h[illegible] alive on 8-1-44 19

Immediate cause of death	Duration
Sub-arachnoid hemorrhage	
Due to	
Due to	
Other Conditions Bilat. lobar pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Hunter Offutt M.D.
M. D.

Address Univ. Hosp. Date signed 8-1-44

G19551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

G19551

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
City or town Balto. Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Ft. Bay ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Theodore Price Brigham

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-40

8. AGE: Years	Months	Days	If less than one day
3	8	10	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name Theodore O. Brigham
13. Birthplace New Bedford Mass

MOTHER
14. Maiden Name Dorothy Stevens
15. Birthplace Woods Hole Mass

16 (a) Informant hosp. record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

8-3-1944 Date rec'd by reg. Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1944 to 8-1 1944 and that I last saw him alive on 8-1 1944

Immediate cause of death Respiratory failure — Duration —
Due to poliomyelitis, paralytic (bulbar) — Duration 4 d
Due to — Duration —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp Date signed 8-2-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19552 94a

G19552 Registered No.

G19552

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 762 Grantley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 762 Grantley St (If rural give location)
(e) Citizen of foreign country? Bromley (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES Franklin THOMPSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-05-0147

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dallas E. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1899

8. AGE: Years 45 | Months 7 | Days 0 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Chauffeur

11. Industry or business: Yellow Cab Co.

FATHER
12. Name: Harry T. Thompson
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Anderson
15. Birthplace: Howard Co., Md.

16 (a) Informant: Mrs. Dallas E. Thompson
(b) Address: 762 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: 1044 Hunting Balto., Md.

AUG 3 1944
(a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. T. Wallenwater M.D. Medical Examiner.
Date signed 8-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

RIGHTS RESERVED FOR BINDING

G19553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G19553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Edgewood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Louise Bloedorn

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1926

8. AGE: Years: 18 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Raymond H. Bloedorn
13. Birthplace Chicago, Ill.

MOTHER
14. Maiden Name Louise M. Weis
15. Birthplace Baltimore

16 (a) Informant Mr. Raymond H. Bloedorn
(b) Address 3507 Edgewood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.,
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1944, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Inquestion (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull. puncture wound of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 15-10

(a) Date of injury August 1 1944 11:65 P.M.
(b) Where did injury occur? Liberty Hgts & Grenada Ave
(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? No
(d) Means of injury Auto ran into telephone pole

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed August 3 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G19554 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belleona Ave
(c) Hospital or institution Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. 39th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Phillips (PHILLIPS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wm. J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lester Hebbeard
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. J. Phillips
(b) Address 311 E 29th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location Lot North Ave

18 (a) Funeral director John C Horan
(b) Address 3600 E Baltimore St

AUG 3 - 1944 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5 1944 to Aug. 31 1944 and that I last saw h[illegible] alive on July 18 1944

Immediate cause of death: Cerebral Hemorrhage with Hemiplegia — Duration 5 mos.

Due to Arterio sclerosis & Hypertension — Duration yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert W. Garis M. D.
Address 1014 St. Paul St. Date signed 8/2/44

G19555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G19555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 592 Wash Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 592 Wash Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Myrtle Celest Bathgate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edward Bathgate (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec 23 - 1907

8. AGE: Years 36 | Months 7 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business Home

FATHER 12. Name Edgar Sifford

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Stella Dietzel

15. Birthplace Baltimore

16 (a) Informant Edward Bathgate

(b) Address 592 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

18 (a) Funeral director Charles P Towell

(b) Address 2427 Edmondson Ave

19 (a) (Date received by registrar) Huntington Williams, M.D.

AUG 3 - 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1944, to Aug 2 1944, and that I last saw her alive on Aug 2 1944.

Immediate cause of death Carcinomatosis - Duration June 7 '44

or Sec not known.

Due to -

Due to -

Other Conditions -

(Include pregnancy within 3 months of death)

Date of operation June 7-1944

Major findings of operation: Carcinoma of all pelvic organs -

of autopsy: -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury -

23. Signature Louis F. Krumeich M. D.

Address 722 N. Kenwood Ave Date signed Aug 2/44

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

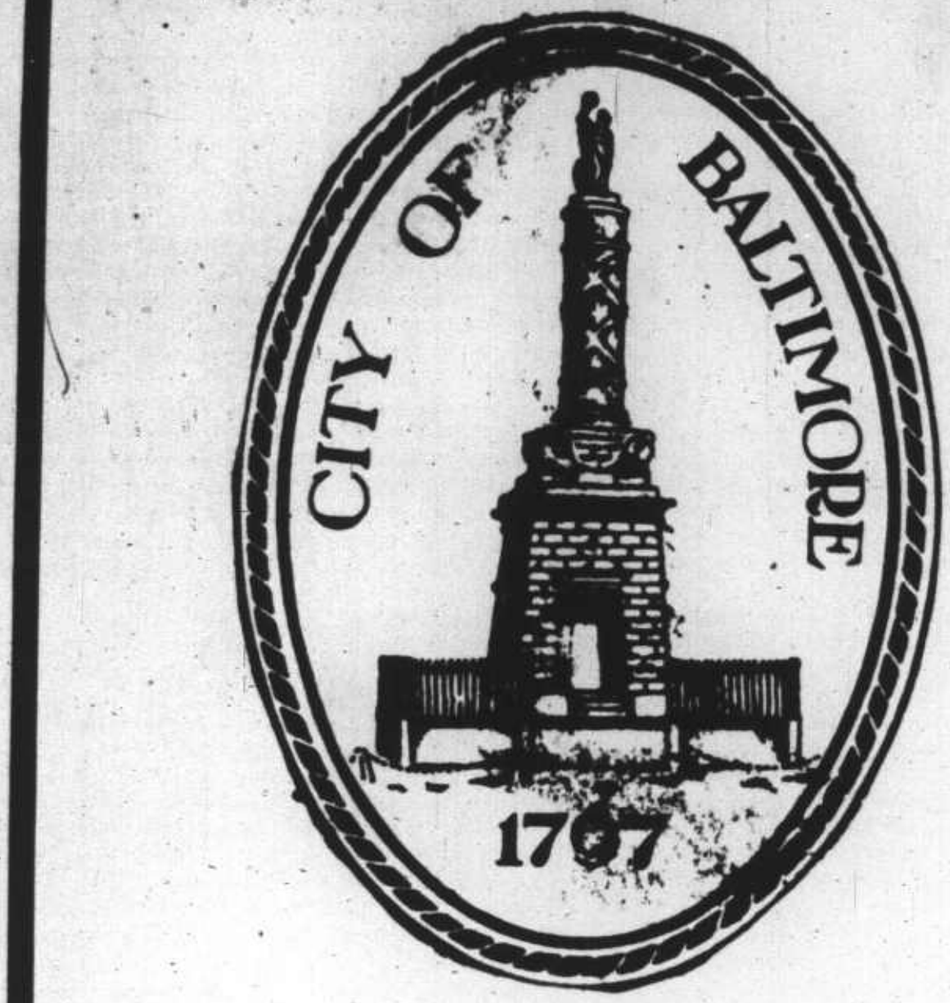
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 7/24 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 16501 AND ENDING WITH 19555 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne



END OF REEL